

DOCKET

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Status: GRANTED

Title: Timothy A. Patrick, Petitioner
v.
William M. Burget, et al.

Docketed:
January 9, 1987

Court: United States Court of Appeals
for the Ninth Circuit

Counsel for petitioner: Lyon, Barbee

Counsel for respondent: Triplett, Thomas M.

Entry	Date	Note	Proceedings and Orders
1	Jan 9 1987	G	Petition for writ of certiorari filed.
3	Feb 9 1987	G	Motion of Joint Commission on Accreditation of Hospitals, et al. for leave to file a brief as amici curiae filed.
2	Feb 11 1987		DISTRIBUTED. February 27, 1987
4	Feb 12 1987		DISTRIBUTED. February 27, 1987. (Above motion).
5	Feb 17 1987	X	Brief of respondents William Burget, M.D., et al. in opposition filed.
6	Feb 26 1987	X	Reply brief of petitioner Timothy A. Patrick filed.
7	Mar 2 1987		Motion of Joint Commission on Accreditation of Hospitals, et al. for leave to file a brief as amici curiae GRANTED.
9	Mar 2 1987	P	The Solicitor General is invited to file a brief in this case expressing the views of the United States. Justice Blackmun OUT.
10	Jul 14 1987		Brief amicus curiae of United States filed.
11	Jul 15 1987		REDISTRIBUTED. September 28, 1987
12	Sep 8 1987	X	Supplemental brief of respondent William Burget, M.D. filed.
13	Oct 5 1987		Petition GRANTED. Justice Blackmun OUT. *****
15	Nov 12 1987		Order extending time to file brief of petitioner on the merits until November 27, 1987.
16	Nov 20 1987		Record filed.
		*	Certified copy of original record and proceedings received. 21 vols.
18	Nov 25 1987		Brief amicus curiae of American Psychological Assn. filed.
21	Nov 25 1987		Brief amicus curiae of Central and South West Corp. filed.
17	Nov 27 1987		Brief of petitioner Timothy A. Patrick filed.
19	Nov 27 1987		Brief amici curiae of Assn. of American Physicians & Surgeons, et al. filed.
20	Nov 27 1987		Brief amicus curiae of United States filed.
22	Nov 27 1987		Joint appendix filed.
23	Dec 14 1987	D	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
25	Dec 21 1987		Order extending time to file brief of respondent on the merits until January 8, 1988.
26	Jan 5 1988		SET FOR ARGUMENT. Monday, February 22, 1988. (4th case). (1 Hour).
27	Jan 5 1988		CIRCULATED.
29	Jan 8 1988	X	Brief of respondents William M. Burget, M.D., et al. filed.
30	Jan 8 1988		Brief amici curiae of Bd of Medical Quality Assurance of the

Entry	Date	Note	Proceedings and Orders
		State of CA, et al. filed.	
31	Jan 8 1988	Brief amicus curiae of Federation of State Medical Boards of the US filed.	
32	Jan 8 1988	X Brief amici curiae of AMA, et al. filed.	
28	Jan 11 1988	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument DENIED. Justice Blackmun OUT.	
33	Feb 8 1988	X Reply brief of petitioner Timothy A. Patrick, M.D. filed.	
34	Feb 22 1988	ARGUED.	

**PETITION
FOR WRIT OF
CERTIORARI**

86 - 1145

No. _____

FILED

JAN 9 1987

JOSEPH E. SPANICK, JR.
CLERK

IN THE
Supreme Court of the United States

OCTOBER TERM, 1986

TIMOTHY A. PATRICK, M.D.,
Petitioner,
v.

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTLEKAMP, M.D.
PATRICK MEYER, M.D.
- GARY M. BOELLING, M.D.
ROBERT D. NEIKES, M.D.
FRANKLIN D. RUSSELL, M.D.
LEIGH C. DOLIN, M.D.,
RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,
Respondents.

**PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

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QUESTIONS PRESENTED FOR REVIEW

1. Where a statute required a private hospital to maintain procedures for peer review by the staff physicians of each other, did a bad faith abuse of the peer review process for anticompetitive reasons amount to state action which is immune from the antitrust laws?

2. Where one of the respondents served on the State Board of Medical Examiners, and abused his position, does the state action doctrine protect him as well as other respondents who were in conspiracy with him, when the damages arose entirely or almost entirely from actions outside his official capacity? Does the state action doctrine require that evidence of that abuse of position be kept from the jury?

LIST OF PARTIES

There are no parties not named in the caption. The respondent Leinassar has died, however, and a motion is pending to substitute his personal representative.

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IN THE
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OCTOBER TERM, 1986

No. _____

TIMOTHY A. PATRICK, M.D.,
v. *Petitioner,*

WILLIAM M. BURGET, M.D.,
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Respondents.

**PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

CITATION TO OPINION BELOW

The opinion below of the Court of Appeals is *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986).

**STATEMENT OF THE GROUNDS ON WHICH THE
JURISDICTION OF THE COURT IS INVOKED**

The judgment of the Court of Appeals was entered on September 30, 1986. The order denying the petition for

rehearing was filed on November 26, 1986. The statute which confers jurisdiction on this Court to review the judgment in question is 28 U.S.C. § 1254(1).

STATUTES INVOLVED IN THIS CASE

Sherman Act § 1, 15 U.S.C. §1:

"Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal * * *."

Sherman Act § 2, 15 U.S.C. § 2:

"Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony * * *."

Oregon Revised Statutes § 441.055:

"(3) The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility. The governing body shall:

* * *

(c) Insure that procedures for granting, restricting and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and

(d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care."

Oregon Revised Statutes § 41.675(4):

"A person serving on or communicating information to any governing body or committee described

in subsection (1) of this section [governing bodies or committees of a health care facility licensed under Ore. Rev. Stat. Chapter 441, including medical staff committees in connection with the grant, denial, restriction or termination of clinical privileges at a health care facility] shall not be subject to an action for civil damages for affirmative actions taken or statements made in good faith."

STATEMENT OF FACTS

Although the opinion of the Court of Appeals is adverse to petitioner, it does state accurately all the necessary facts. The jury had found that respondents deprived petitioner of hospital privileges in the course of a conspiracy or attempt to monopolize the practice of surgery in the relevant market. The Court of Appeals analyzed the evidence against them as follows:

"There was substantial evidence that the defendants acted in bad faith in the hospital's peer review process and in the [State of Oregon Board of Medical Examiners] proceedings. * * * There is no doubt that the evidence, viewed in the light most favorable to Patrick, reveals shabby, unprincipled and unprofessional conduct on the part of the defendants." Appendix 12a, 17a.

Nevertheless, the Court of Appeals held that defendants' actions were immune from the Sherman Act on account of the "state action" doctrine, and reversed the judgment in favor of petitioner.

What follows is a summary of the facts stated in the Court of Appeals' opinion, together with a few consistent additional facts.

Astoria is a city of 10,000 in northwestern Oregon. (Appendix 2a). It has only one hospital. (*Id.*) There are 20-25 doctors who have staff privileges at the hospital. (Tr. 156, 182, 1271; Agreed Facts, Exc. Rec. 19.) Two-thirds of them are partners or employees of a single

clinic, the Astoria Clinic. (Appendix 3a; Tr. 156-57, 182, 184.) Astoria Clinic physicians control the Executive Committee of the hospital. (Tr. 185, 2448.)

When petitioner finished his surgical residency, the Astoria Clinic invited him to Astoria to become the Clinic's surgeon. (Appendix 2a; Ex 3.) Petitioner accepted, obtained surgical privileges at the hospital, and began practicing. (Tr. 180.) After one year, the Astoria Clinic offered him a partnership. (Appendix 2a; Tr. 179.) He declined, however, and left the Astoria Clinic to establish his own independent surgical practice. (Appendix 2a-3a.)

The Astoria Clinic doctors reacted negatively. (*Id.*) Surgery is a lucrative specialty. (Tr. 141, 144, 149, 152, 153, 1138.) The Astoria Clinic doctors resented petitioner's setting up a competing surgical practice. (Appendix 3a; Tr. 188, 1141). No one had ever done so before. (Tr. 192, 1168.) They hampered petitioner's practice in a variety of ways which are detailed in the opinion of the Court of Appeals. (Appendix 3a-8a.)

Petitioner's practice nevertheless grew and thrived. (Tr. 219.) In 1979 he hired a new young surgeon to help him, so that his clinic had two surgeons to the Astoria Clinic's one. (Appendix 3a; Tr. 195.) Relations with the Astoria Clinic doctors thereupon worsened. (Appendix 4a.)

They first brought charges against him before the Oregon State Board of Medical Examiners, where one of their number, Dr. Russell, had just been made chairman of the investigative committee. (Appendix 5a; Tr. 712; Agreed Facts, Exc. Rec. 22.) Although Dr. Russell announced a conflict of interest on the record in the presence of petitioner and his attorney, and declared that he would not participate, it was later discovered that in closed proceedings he was the antagonist against petitioner. (Appendix 4a-5a.) The Court of

Appeals characterized his behavior in this matter as "duplicity". (Appendix 16a.) He drafted for the signature of another Board member who was not aware of the conflict of interest a public letter of reprimand which was published throughout the hospital. (Appendix 5a; Ex. 51) The letter was a grossly inappropriate and unfair punishment: it harshly criticized petitioner's handling of 15 patients, even though petitioner had previously been told that only one was under consideration and didn't even know who the other 14 were, so that he had no notice or hearing at which he could present his side. Tr. 554; Ex. 51, 54). In secret, Russell opposed telling petitioner the names of 14 of the 15 patients for whose care he was publicly reprimanded, and opposed his request for an opportunity to present his side. (Appendix 6a.) The letter also severely misrepresented the report of consultants to the Board, which in part had exonerated petitioner and criticized his attackers. (Ex. 51, 173.) The Board eventually withdrew the letter in its entirety, and the Chairman of the Board testified voluntarily in petitioner's behalf in the trial of this action below. (Appendix 6a; Tr. 1022.)

The letter being withdrawn, it was in peer review proceedings in the hospital that petitioner was ultimately injured. Astoria Clinic doctors attacked petitioner's treatment of various patients, while shielding their own members and allies from criticism. (Appendix 6a.) Eventually, the Clinic doctors moved to terminate petitioner's privileges at the hospital. (Appendix 7a; Ex. 82, 1292.) Charges against him were drawn up in a meeting in the Astoria Clinic board room, and a committee of five, only one of whom was independent of the Astoria Clinic, was appointed to hear the charges. (Appendix 7a; Tr. 110 et seq., 123-28, 165, 311-12, 585, 587, 905, 906, 908, 913, 921, 1153, 1165; Agreed Facts, Exc. Rec. 22.) Petitioner proposed that an independent panel be appointed instead, and offered to abide by the decision of such a panel. (Ex. 91, 107.) His proposal was rejected. (Ex. 109.)

The hearings commenced. As the Court of Appeals said, the committee was inattentive to his presentation. (Appendix 8a.) The court reporter testified that there was a lot of attention given to the prosecution side, little to petitioner's defense. (Tr. 1492) The Chairman, respondent Boelling—who unknown to petitioner had previously given secret testimony against petitioner on three of the nine charges on which he now sat as judge—read Time magazine and medical journals. (Tr. 353, 1156-58, 1205, 1741-42.) Others tied fishing lures or filled out patient charts. (Tr. 352-53, 907, 2223.) After these and other events convinced petitioner that the result was foreordained, he resigned. (Appendix 8a; Tr. 356-57.)

By this time petitioner had already filed this action against the respondents, who are partners in the Astoria Clinic, charging them with attempting to monopolize the practice of surgery in Astoria, among other things. (Appendix 8a.) The jury trial lasted three weeks. The jury was instructed to decide in favor of the respondents if it found their conduct was predominantly motivated by legitimate professional concerns over provision of health care to the community. (Tr. 2922-28). However, the jury unanimously found that the Astoria Clinic instead had attempted to monopolize the practice of surgery in Astoria, and found three of their number to have conspired in restraint of trade. (Appendix 8a.) As a result of petitioner's loss of hospital privileges, the jury awarded \$650,000 in actual damages for the antitrust violations. (*Id.*) The trial judge denied defendants' motion for directed verdict and new trial, and entered judgment on the verdict for treble damages. However, the Court of Appeals for the Ninth Circuit subsequently held that respondents were immune from the antitrust laws, and reversed.

BASIS FOR JURISDICTION IN THE U.S. DISTRICT COURT

15 U.S.C. §§ 15, 22; 28 U.S.C. § 1331.

ARGUMENT FOR ALLOWING THE WRIT OF CERTIORARI

The issue presented by this case is one which arises in most states, and is of wide public importance. The lower courts are in disagreement: although the Ninth Circuit agrees with the Seventh Circuit, and no other court of appeals is contrary, two district courts have considered the reasoning of the Seventh and Ninth Circuits in lengthy opinions and expressly rejected it. This case itself was the primary impetus for a recent Act of Congress which, although suggesting error in the decision below, has left it for the courts—for this Court—to resolve.

I. THE ISSUE PRESENTED BY THIS CASE IS ONE WHICH ARISES IN MOST STATES AND IS ONE OF WIDE PUBLIC IMPORTANCE.

Peer review is the process by which a hospital decides which physicians shall be permitted to practice medicine in the hospital. That decision is made on behalf of the hospital by the other physicians who have hospital privileges. Often these other physicians are competitors. The peer review process therefore permits one group of competitors to exclude another competitor from an essential facility, and therefore from the market. As the Court of Appeals observed, this raises antitrust concerns:

"An analogous scheme would allow General Motors, Chrysler and Ford to review the safety of Toyotas to determine if the public should be allowed to drive them." Appendix 12a.

Peer review is nevertheless widespread because it is one means of protecting the public from incompetent or negligent physicians. At least thirty-six states therefore either require or provide for peer review in hospitals licensed by the state.¹

¹ Ala. Code § 34-24-58 (1985), § 6-5-333 (Supp. 1986); Alaska Stat. § 18.23.010, .020 (1986); Ariz. Rev. Stat. Ann. § 36-2401, 2402

However, most states also recognize the possibility that peer review may sometimes be perverted for the selfish ends of the participants, as happened in this case. Thirty-one of the thirty-six states, including Oregon, therefore grant only a limited immunity to participants, and refuse to protect them if they act in bad faith, or with malice, or fraud.²

This tension between peer review and antitrust has provoked increasing attention in the last few years. A 1982 law review article noted that "disappointed applicants for hospital privileges have begun to file an increasing number of antitrust claims against hospitals and medical staffs in recent years." Kissam, Webber, Bigus and Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 596

(Supp. 1986); Ark. Stat. Ann. § 82-3201, 3202 (1976); Cal. Health & Safety Code § 1370 (West 1979 and Supp. 1987), Cal. Civ. Code § 43.7 (Supp. 1987); Colo. Rev. Stat. § 12.43.5-102, 103 (1985 and Supp. 1986); Conn. Gen. Stat. § 38-19a (Supp. 1986); Del. Code Ann. tit. 24, § 1768 (1981); Fla. Stat. Ann. § 768.40 (West 1986); Ga. Code Ann. § 88-3201, 3202 (1986); Hawaii Rev. Stat. §§ 624-25.5, 663-1.7 (1976); Idaho Code § 39-1392f (Supp. 1986); Ill. Ann. Stat. ch. 111½, § 10.2 (Smith-Hurd Supp. 1986); Ind. Code Ann. § 34-4-12.6-1, 3 (Burns 1986); Kan. Stat. Ann. § 65-442, 4914 (1985); Ky. Rev. Stat. § 311.377 (1983); La. Rev. Stat. Ann. § 3715.3 (West Supp. 1986); Me. Rev. Stat. Ann. tit. 24, § 2501, 2511 (Supp. 1986); Miss. Code Ann. § 41-63-1, 5 (Supp. 1986); Mo. Ann. Stat. § 537.035 (Vernon Supp. 1987); Mont. Code Ann. § 37-2-201 (1985); Neb. Rev. Stat. § 71-2046 (1981); N.H. Rev. Stat. Ann. § 507:8-c (1984); N.J. Stat. Ann. § 2A:84A-22.10 (West Supp. 1986); N.M. Stat. Ann. § 41-9-2, 4 (1986); Ohio Rev. Code Ann. § 2305.25 (Page Supp. 1985); Okla. Stat. Ann. tit. 63, § 1-1709 (West 1984), tit. 76, § 16 (West Supp. 1987); Or. Rev. Stat. §§ 41.675, 441.055 (1985); Tenn. Code Ann. § 63-6-219 (1986); Tex. Civ. Code Ann. § 1.03 (Vernon Supp. 1987); Utah Code Ann. § 58-12-43 (1986); Vt. Stat. Ann. tit. 16, §§ 1441, 1442 (Supp. 1986); Va. Code § 8.01-581.16 (1984); Wash. Rev. Code Ann. § 4.24.240 (Supp. 1987); W. Va. Code § 30-3C-1, 2 (1986); Wis. Stat. Ann. § 146.37 (West Supp. 1986).

² See statutes cited in footnote 1.

(1982). Many other such claims have followed since. It is reported that such claims account for one half of the health care antitrust suits.³

However, it is this present case in which certiorari is now sought which has most precisely focussed the issue and drawn the greatest attention.⁴ The appeal from the District Court to the Ninth Circuit elicited amicus curiae briefs from a number of parties, including the American Medical Association and the Joint Committee on Accreditation of Hospitals.

Indeed, this present case eventually led to an Act of Congress.⁵ 132 Cong. Rec. H9960 (daily ed. October 14, 1986) (statement of Rep. Edwards). This new Act establishes minimum standards for peer review (the statute uses the term "professional review") and protects participants against liability for damages under both state law and federal law.⁶

However, this recent Act does not resolve the question decided by the Court of Appeals below. Instead, it makes it more important that this Court grant review. The immunity provided by the Act is limited only to persons who act in good faith, i.e., "in the reasonable belief that

³ *Attempts to Gain Access to Hospitals Are Prevalent in Health Care Actions*, 46 Antitrust & Trade Reg. Rep. (BNA) No. 187, § 1174 at 187 (Feb. 2, 1984).

⁴ Because there was no opinion in the District Court, the meaning of the verdict and judgment was sometimes misunderstood in articles written about this case in the popular press before the Ninth Circuit decision clarified what was at stake. See, e.g., Snow, *Trust Versus Antitrust*, Atlantic Monthly, September 1986, at 26. Until the Ninth Circuit delivered its opinion, the extent of defendants' bad faith was not widely appreciated.

⁵ The Health Care Quality Improvement Act of 1986, Title IV (Encouraging Good Faith Professional Review Activities) of the State Comprehensive Mental Health Services Plan Act of 1986, Pub. L. No. 99-660.

⁶ Sec. 411(a)(1)(D).

the action was in the furtherance of quality health care" and "in the reasonable belief that the action was warranted by the facts known * * *".⁷ The Ninth Circuit opinion, by contrast, went much further and extended immunity even to participants who act in bad faith. That this Act left unresolved the question now presented to this Court was expressly recognized by Rep. Waxman who carried the bill in the House and who compared it to the Ninth Circuit opinion in this case:

"* * * I would make the following point with respect to the Patrick case and the antitrust laws. It is my understanding that a number of antitrust experts believe that the Ninth Circuit has extended the State action doctrine in Patrick farther than seems warranted by recent Supreme Court rulings. If appealed, the Patrick case may well be overruled or modified. If Patrick is upheld, the immunity from damages in antitrust actions granted by H.R. 5540 will be irrelevant in many States. If Patrick is overruled or modified, the immunity obtained under H.R. 5540 will be substantially narrower than the State action doctrine enunciated in that case. *Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540.*" 132 Cong. Rec. H11590 (daily ed. October 17, 1986) (statement of Rep. Waxman). (emphasis added)

Rep. Waxman articulated an uncertainty about the law which must make peer review a more troubled process for every physician and every hospital in the nation. Although Congress was willing to legislate only a good faith immunity, it left it to this Court to decide whether the *Patrick* principle of absolute immunity also is valid.⁸ This uncertainty can be resolved only if this

⁷ Sec. 412(a) (1), (4).

⁸ The state action doctrine which the Court of Appeals attempted to apply in this case is a judicial doctrine which this Court has developed and whose very basis is to determine the intent of Congress. *Parker v. Brown, infra*. The recent Act of Congress is a

Court accepts review in this case and either upholds or overrules the decision below. Until then, where is the point of balance between peer review and antitrust? What *are* the rights of any physician in the future who is victimized by a similar abuse? No lawyer can give any sure advice. For in addition to the tension between this recent statute and the Ninth Circuit decision below, the lower courts themselves are arrayed in opposite positions, as will be demonstrated later.

II. THE DECISION BELOW IS NOT JUSTIFIED BY THE STATE ACTION DOCTRINE.

The state action doctrine emerged in this Court's decision in *Parker v. Brown*, 317 U.S. 341 (1943). California had imposed controls on raisin growers and prohibited competition in price and marketing. *Id.* This Court rejected an antitrust challenge to the California scheme, holding that Congress did not intend for the Sherman Act to prohibit states from imposing restraints on competition in order to regulate their domestic competition. Later, in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), this Court considered another California statutory system which required all wine producers and wholesalers to set prices by contract or price schedule filed with the appropriate state agency. This Court established a test for determining whether a particular anticompetitive practice is sanctioned by the state action doctrine:

"First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised by the State itself.'" *Id.* at 105.

sign that the intent of Congress may not be what the Ninth Circuit thought it was. Since this latest statute is so recently enacted, and was not considered by the Court of Appeals, petitioner respectfully suggests that one alternative disposition would be to reverse summarily and remand to the Ninth Circuit for reconsideration in light of the new statute.

Because California neither established prices nor reviewed or regulated the terms of the contracts and price schedules, it did not satisfy the second prong of the state action standard.

The Ninth Circuit misapplied both aspects of the *Midcal* test. There is no clearly articulated and affirmatively expressed state policy which would tolerate what happened. Nor is the state involved in any significant way at all in supervision.

A. The Court of Appeals was wrong in holding that the challenged restraint satisfied the first prong of the state action doctrine, that the restraint be clearly articulated and affirmatively expressed as state policy.

1. *The Court of Appeals misinterpreted state policy.*

The restraint which petitioner challenged was defendants' attempt or conspiracy to monopolize the practice of surgery.⁹ That was the restraint which the jury found to exist. The Ninth Circuit reasons as follows in holding that this restraint is pursuant to clearly articulated state policy.

First, the Court of Appeals observes that Oregon law does require peer review in hospitals. Ore. Rev. Stat. 441.055. Second, the Court of Appeals infers from this statute an intent to replace competition with regulation, and an intent that it shall be competitors who regulate each other. The Court of Appeals therefore finds that the state of Oregon has immunized as an act of the state itself the bad faith perversion of the peer review process which the Court of Appeals found to exist here.

This conclusion is bad law and worse policy.

⁹ This analysis also applies to the verdict on the Sherman Act Section 1 count of a conspiracy in restraint of trade.

It is not even correct to say that this statute replaces competition with regulation. The physicians who decide privilege questions must nevertheless do so as representatives of the hospital, pursuing the purposes of the hospital and of the statutes, putting aside any personal anti-competitive motive. A state is surely justified in supposing that at least in most cases the high ethical standards of the medical profession will suffice to accomplish that. In one sense the statute contemplates competitors reviewing competitors, but in the more fundamental sense, it does not: it contemplates that physicians will leave behind their role as competitors when they pass judgment on the qualifications of other physicians.¹⁰

There is only one "clearly articulated and affirmatively expressed" state policy: this statute is only "for the purposes of reducing morbidity and mortality and for the improvement of patient care." Ore. Rev. Stat. 441.055. If this policy of the statute is honored, a more rigorous review of physicians' qualifications will follow, and competition among them for access to the hospital will be sharpened. If the hospital thereby exercises care in choosing the best physicians, it is procompetitive, just as it is procompetitive for the hospital to exercise care in choosing the best xray equipment.

What happened here was a consequence of a violation of the state policy, not of its enforcement. That the statutes create a situation which some physicians may be tempted to abuse does not mean that that abuse is a clearly articulated state policy. Suppose a group of physicians were to use peer review to punish another who charged lower prices for medical service. Under the Ninth Circuit's reasoning, such price fixing would be immune state action.

¹⁰ The statute does not even necessarily contemplate review of competitors by competitors. Not all physicians on staff compete with each other, for a variety of reasons. Internists, for example, do not necessarily compete with surgeons unless—as in this case—they are partners with another surgeon and share surgical fees.

The Court of Appeals noted that there was a great deal of testimony that petitioner was "quite a good surgeon". Appendix 4a. There was also evidence that he was certainly better than the Astoria Clinic surgeon, who the Court of Appeals observed was not subjected to scrutiny. Appendix 6a-7a; Tr. 860. The abuse of monopoly power, as in this case, is directly contrary to the state policy. It protects the inferior surgeon and drives out the better, to the detriment of patient care.

It is of course conceivable that a state might choose to give absolute immunity to all who participate in peer review, regardless of motive, perhaps in order to encourage more robust peer review. Oregon, however, has intentionally chosen a different policy, as have 30 other states, and as has Congress. Yet from this express state policy that only good faith actions shall be immune, the Court of Appeals derives a holding that state policy requires immunity for bad faith actions. The reasoning is difficult to follow.

2. The opinion is in conflict with well-reasoned decisions of the district courts.

The Ninth Circuit relied on an earlier decision of the Seventh Circuit which came to a similar holding. *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), cert. denied, 105 S. Ct. 3501 (1985).¹¹ There is apparently no decision of any court of appeals in conflict with these decisions of the Seventh and Ninth Circuits. However, two district courts have considered the same question at length and have come to the opposite conclusion. In *Quinn v. Kent General Hospital*, 617 F. Supp. 1226 (D. Del. 1985), the court said:

"* * * this Court is unable to adopt the reasoning of the Seventh Circuit in *Marrese*. The question confronting the Court is not merely whether Delaware had adopted a clearly articulated policy of promot-

¹¹ The facts in *Marrese*, however, were far less egregious than in this case.

ing the medical peer review process but whether the legislature intended to displace competition in the market for hospital facilities. [citations omitted] While it is true that the clear articulation test does not require that the legislature 'expressly state in a statute or its legislation to have anticompetitive effects,' [citation omitted] there is not even a hint in the Delaware statute that the peer review process will be promoted by conferring a monopoly upon those physicians with entrenched positions on hospital staffs. Nor is there any reason why promotion of the peer review process should require any additional restriction of competition. To be sure, this competition must occur within the boundaries of standards established by the medical profession and the state, and within the limits set by the capacity of the available hospital facilities, but there is no reason why the peer review process should be used to place additional restraints on competition; among physicians. Indeed, the peer review process is arguably procompetitive, for by monitoring the qualifications and performance of physicians it may compensate for the relative lack of information about these matters by consumers."

To the same effect is the opinion in *Posner v. Lankenau Hospital*, Trade Reg. Rep. CCH ¶ 67,351 (E.D. Pa., September 9, 1986):

"The Pennsylvania administrative regulations governing health care facilities do not expressly permit anticompetitive conduct by a hospital and its medical staffs. An examination of the regulatory scheme does not reveal an intention to replace competition in the market for hospital medical staff positions among physicians with a regulatory structure. The regulations provide that the denial of medical staff privileges may only be based on professional or ethical grounds, which could be viewed as procompetitive, since it prohibits denials made for purely anticompetitive reasons. Most decisions which are made in any competitive job market are based on professional

or ethical grounds. Allowing medical staffs to make hospital staffing decisions based on professional or ethical grounds is not tantamount to an approval of anticompetitive conduct. That some medical staffs may be able to engage in the anticompetitive conduct while in compliance with the Pennsylvania regulatory scheme does not necessarily demonstrate the legislature intended to permit such conduct.

* * *

"I do not find the reasoning of the court of appeals in *Marrese* persuasive. [citation to *Quinn*, *supra*, omitted]" *Id.* at 61,827-28.

B. The Court of Appeals was wrong in holding that the State of Oregon actively supervised any private anticompetitive conduct.

The second prong of this Court's test for state action is that the state must supervise actively any private anticompetitive conduct. The ways in which the Court of Appeals professed to find active supervision in this case by Oregon are not sufficient.

1. There is no supervision by the Board of Medical Examiners.

The Court of Appeals held:

"When a health care facility terminates or restricts the privileges of a physician, it must promptly report to the [Board of Medical Examiners] all facts and circumstances that caused the termination or restraint. Or. Rev. Stat § 441.820(1). Supervision by the Board, a state agency, is equivalent to supervision by the state." Appendix 10a.

There is a tremendous leap between the first and second sentences. The receipt of information about what has gone on is not equivalent to active supervision of the process which went before. The Board of Medical Examiners has no authority at all over hospitals and their decisions on privileges. There is no appeal to the Board of Medical Examiners, and it cannot compel a hospital to change its decision. It had no power or influence over

the hospital proceedings in this case. All it does is receive information reported to it. Consider, by comparison, that all drivers of automobiles in Oregon must also promptly report changes of address to the Motor Vehicles Division, Ore. Rev. Stat. 807.560, but that does not mean that the Motor Vehicles Division is engaged in active supervision of where people live. Neither can the Board of Medical Examiners "supervise actively" what it has no authority over.

The situation in Oregon parallels that in most of the other 36 states. Few of the statutes previously cited contain any provision for judicial or administrative review of hospital privilege decisions.

2. The possible availability of state law remedies in tort or contract is no evidence of active state supervision.

The Court of Appeals also states:

"The hospital's decisions terminating or restricting privileges are also judicially reviewable. Oregon courts have reviewed adverse privilege decisions to determine if they were made in good faith pursuant to fair procedures and were supported by the facts. See *Straube v. Emmanuel (sic) Lutheran Charity Board*, 287 Or. 375, 600 P.2d 381, 386-87 (1979), cert. denied, 445 U.S. 966 (1980); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398, 1401 (1975)." Appendix 10a-11a.

There are two things wrong with this analysis. First, in both cases on which the Court of Appeals relies, the Oregon Supreme Court expressly refused to hold that a disappointed peer review participant had any right of redress in the courts at all. Second, and more important, if any right of redress existed, it was only a private right in tort or breach of contract. That the State of Oregon *may* hold its courts open to private suits is not to say that the State of Oregon actively supervises whatever led to those suits. The state courts, for example,

are indeed open to litigants to bring actions for defamation and breach of contract, but that does not mean the state actively supervises defaming and breaching of contracts. Many states also provide state law remedies for conspiracies in restraint of trade and attempts to monopolize, but the existence of such state law remedies cannot manifest active state supervision of anticompetitive conduct which thereby immunizes that conduct under federal law.

3. *The procedure by which hospitals are licensed does not constitute active supervision of peer review.*

The Court of Appeals also notes that hospitals are licensed by the state—although not by the Board of Medical Examiners—and that

“To maintain licenses, health care facilities regularly must review privilege termination and restriction procedures to assure their conformity to applicable law. Or. Rev. Stat. § 441.030, 441.055(3)(c).” Appendix 10a.

The state Health Division does license hospitals, and it does have the power to suspend a license for a very wide variety of reasons, including the one to which the Court of Appeals referred. But all that the Health Division can do is to require hospitals to *have* procedures and to require hospitals themselves to review their own procedures. The governing body of this hospital did have such procedures in its bylaws, and there is nothing particularly wrong with them. There is therefore nothing more for the Health Division to do. The statutes do not provide any right of appeal to the Health Division, nor do they provide for the Health Division to supervise actively or even review a termination of hospital privileges.

There is even less state supervision of these peer review proceedings than there was of the posting of price sched-

ules in *California Retail Liquor Dealers Association v. Midcal Aluminum, supra*. Yet this Court reversed the Ninth Circuit in that case, holding that the state was not actively involved in the setting of prices, even though it required their setting. Here too the state only required the peer review, and was not actively involved in it. There was no state agency involved in reviewing what went on in this or any other privilege determination. There is only petitioner, struggling by himself for redress. His plight, however, is representative of physicians in the majority of states who under this ruling are deprived of their best and perhaps only remedy against the abuse of power by their entrenched competitors.

C. Neither should the state action doctrine bar evidence of abuse of the proceedings before the State Board of Medical Examiners.

The Court of Appeals also held that Dr. Russell's activities as a member of the Board of Medical Examiners were also exempt under the state action doctrine. However, the damages which petitioner obtained were based entirely or almost entirely on the deprivation of hospital privileges, which occurred outside and after any proceedings of the Board, for the letter of reprimand had by then been withdrawn. Dr. Russell's "duplicity" with respect to that Board, and that of other respondents who appeared secretly before his committee, was nevertheless evidence both of the bad faith and of the conspiracy which ultimately culminated in the hospital action against petitioner's privileges. The state action doctrine should not be interpreted as requiring the suppression of relevant evidence before the jury. Nor should it be extended to protect sham and surreptitious actions contrary to state policy.

CONCLUSION

The Court of Appeals' opinion, if allowed to stand, threatens the integrity of competition among physicians throughout the country, and sanctions the abuse of monopoly power by the entrenched. It is contrary to the intent of Congress, and confuses the law. Petitioner prays the Court to grant the writ.

Respectfully submitted,

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APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-3759
85-4071

C.A. Nos. 81-260 EL

TIMOTHY A. PATRICK, M.D.,
Plaintiff-Appellee,
vs.

WILLIAM M. BURGET, M.D., JORMA M. LEINASSAR, M.D.,
R. G. KETTLEKAMP, M.D., PATRICK MEYER, M.D., GARY
BOELLING, M.D., ROBERT D. NEIKES, M.D., FRANKLIN
D. RUSSELL, M.D., LEIGH C. DOLIN, M.D., RICHARD
C. HARRIS, M.D., DANIEL M. RAPPAPORT, M.D., and
TZU SUNG CHIANG, M.D. doing business as ASTORIA
CLINIC,

Defendants-Appellants.

Appeal from the United States District Court
for the District of Oregon

Honorable Edward Leavy, District Judge, Presiding

Argued and Submitted March 4, 1986—
Portland, Oregon

[Filed Sept. 30, 1986]

OPINION

BEFORE: FLETCHER, ALARCON and WIGGINS,
Circuit Judges.

FLETCHER, Circuit Judge:

Appellants, partners in the Astoria Clinic, a medical clinic, appeal from a jury verdict in favor of Dr. Timothy Patrick, a surgeon in Astoria, for violations of Sherman Act sections 1 and 2 and for interference with prospective economic advantage under Oregon law. Because the conduct at the heart of the antitrust claims is exempt from liability under the state action doctrine, we reverse the judgment on the Sherman Act claims. Because the trial court failed to instruct the jury properly as to applicable statutory immunities, we reverse the judgment on the state law claims as well. We remand to the district court for determination of whether Patrick has antitrust claims that survive and for a new trial on the state law claim.

BACKGROUND ¹

Astoria is a city of 10,000 located in the northwest corner of Oregon. The only hospital in Astoria is Columbia Memorial. Columbia Memorial is a secondary hospital capable of handling some, but not all, forms of complex surgery.² The nearest hospital, Ocean Beach Hospital in Ilwaco, Washington, is a primary care hospital. During the relevant time frame, a majority of the Columbia Memorial medical staff were employees or partners of the Astoria Clinic.

Appellee Timothy Patrick is trained in general and vascular (blood vessel) surgery. In 1972, he joined the Astoria Clinic. After his initial one-year contract expired, he was asked to become a partner. Because he felt he had not been paid in proportion to the income he had produced for the Clinic, he chose to open an inde-

¹ We present the evidence in the light most favorable to Patrick.

² Hospitals are classed as primary, secondary and tertiary in increasing order of sophistication.

pendent practice in Astoria. James Weber is a general surgeon who came to Astoria as an employee of Patrick in 1979. Patrick fired him in 1981 and Weber, in turn, set up an independent practice in Astoria.

Appellants William Burget, Jorma Leinasser, Richard Kettlekamp, Patrick Meyer, Gary Boelling, Robert Niekas, Franklin Russell, Leigh Dolin, Richard Harris and Daniel Rappaport were all partners in the Astoria Clinic when this suit was filed in 1981. Appellant Tzu Sung Chiang was added to the suit when he became a partner in 1982.³

From the outset the doctors in the Clinic reacted negatively to Patrick's establishment of an independent practice. Patrick received virtually no surgical referrals from the Clinic. During a period when there was no general surgeon at the Clinic, patients were referred to hospitals 50 or more miles away for surgery. If Patrick (or Weber, when he was associated with Patrick) treated a "Clinic patient," the Clinic doctors would react angrily. The record contains several examples of confrontations resulting from the perceived theft of patients. Some of these took place in front of the patients themselves. The Clinic doctors also were not interested in helping Patrick with his own patients. Clinic surgeons consistently refused to enter cross-coverage agreements with Patrick that would provide care for each other's patients if one of them needed to be out of town. Clinic doctors also were reluctant to give consultations. At the same time, the Clinic doctors repeatedly criticized Patrick for failure to get outside consultations and adequate back-up coverage.

The pattern of treatment of emergency room patients suggested that the Clinic doctors were attempting to make

³ The only other partner at the time the suit was filed, Leroy Steinmann, was originally named as a defendant, but was dismissed at the close of Patrick's case at trial.

Patrick's patients their own and to prevent new ones from seeing him. Witnesses testified that they had come to the emergency room, asked for Dr. Patrick, and were told he was not available. Later, they discovered that Patrick was available and that no attempt had been made to contact him. Emergency room patients without a regular doctor tended to be treated by Astoria Clinic doctors rather than Patrick or Weber. During the period when the Clinic had no general surgeon, surgical emergencies were often sent to out of town hospitals rather than to Patrick.

The Clinic doctors explained that their reluctance to deal with Patrick was due to his contentiousness and lack of skill. However, there was uncontroverted testimony that Patrick never had any trouble getting along with the doctors at Ocean Beach and that he had been offered a partnership in the Astoria Clinic. There also was a great deal of testimony that Patrick was quite a good surgeon.

In the fall of 1979, after Weber had joined Patrick, the difficult relations between Patrick and the Clinic doctors erupted into more serious confrontations. The Clinic doctors attacked Weber in various ways soon after his arrival, and they increased their hostility toward Patrick. However, as soon as Weber left Patrick's employ, he was invited to join the Clinic.

An incident that triggered disciplinary action against Patrick occurred shortly after Weber's arrival. Patrick operated on a Mr. Willie to repair injuries suffered in an accident. Patrick almost immediately left town for the weekend. He left Weber in charge, even though Weber was scheduled to leave for Chicago Sunday morning. Patrick told Weber to check in on Willie early Sunday and, if he looked fine, to ask Dr. Linehan, a general practitioner, to cover until Patrick's anticipated return Sunday afternoon. Weber checked on Willie at 5:00 a.m., and, finding him stable, left for Chicago.

Before Patrick returned, Willie's condition worsened. The nurses called Dr. Linehan, who did not feel competent to handle the problems that had arisen. Without calling Patrick, who was only 90 minutes away by car, Linehan asked Dr. Boelling for help. Boelling refused, saying that he had bailed Patrick out enough. The hospital chief of staff then assigned Dr. Harris, a Clinic surgeon, to the case. Patrick would have returned immediately had he been called.

Boelling wrote a letter complaining about Weber's handling of the case. The hospital staff executive committee decided to refer the Willie matter to the Oregon Board of Medical Examiners (BOME) along with charts from 14 other cases ostensibly handled by Patrick. At the time the executive committee sent the charts, the three-member investigative committee of the BOME was chaired by Dr. Russell of the Astoria Clinic. Drs. Boelling and Harris testified at the request of the investigative committee.

When Patrick and Weber met with the investigative committee, they were assured that the Willie case was the only case of Patrick's under review. Russell told them he would not participate in discussion of the case because of a "conflict" between them and his "group." However, the chairman of the BOME, Dr. Tanaka, was never informed of the conflict of interest, and Russell proceeded to brief the whole Board on Patrick's cases. Patrick and Weber then spoke with the full Board; again, only the Willie case was discussed.

The BOME voted to issue a reprimand letter. Russell was asked to draft it. The Board issued Russell's draft, with some changes made by the BOME administrator. The letter stated that it was based on the evaluation of fifteen charts; it criticized Patrick's handling of the Willie case, and noted that Patrick was careless in his medical practices generally. After receiving the letter, Patrick wrote to the BOME requesting a review of the

proceedings. Over Russell's objection, the BOME sent Patrick a list of the 14 other charts that had been reviewed. Patrick had not been the treating doctor in some of the cases. He again wrote to the BOME, threatening legal action unless a new hearing was granted or the letter withdrawn. Again over Russell's objection, Tanaka agreed to meet with Patrick.

At the meeting, Patrick acknowledged that the BOME's criticism of the Willie matter was justified. After discussion of the other charts, Tanaka agreed the letter overstated matters. However, the BOME did not retract or amend the letter after Russell indicated that he knew of other cases of Patrick's that would justify the criticism. After Patrick filed a petition for judicial review, the BOME retracted the letter entirely.

In the peer review proceedings within the hospital, Patrick's cases were reviewed by Clinic doctors, were discussed more often and criticized more thoroughly than those of other surgeons. For a period of several months, while Dr. Harris was Chief of Surgery, Patrick was given no cases of other doctors to review at all. He threatened to withdraw from the peer review process completely unless it was administered fairly. A rotating system of review was established and, subsequently, there were fewer problems. However, Patrick put forth numerous examples at trial to demonstrate that cases of other doctors similar to those that got him into serious trouble went unreviewed by the hospital's processes.⁴

⁴ The most serious evidence of unequal treatment involved a Dr. McLaughlin, an alcoholic. In his early years in Astoria, there were times he could not be reached when he had been drinking. In 1978, while employed by Dr. Foster, a non-Clinic doctor, McLaughlin had some sort of breakdown during an operation and could not proceed. The hospital chiefs of staff and of surgery told Foster that subsequently he would have to chaperone McLaughlin whenever he operated. Foster fired McLaughlin, who then set up independent offices in the Astoria Clinic building. Although he began attending Alco-

Harris, in particular, seems to have been free from scrutiny.

In 1981, at Harris's urging, the medical staff began proceedings to terminate Patrick's privileges at the hospital. The executive committee voted to recommend termination of privileges because Patrick's care of his patients was below the standards of the hospital. Patrick was allowed a hearing at which the executive committee presented the case against him, and he presented a defense. The charges against Patrick were drawn up at a meeting at the Astoria Clinic board room attended by the hospital administrator, an attorney appointed by the hospital to represent the executive committee, Drs. Kettlekamp and Harris. The charges originally encompassed 21 cases, some of which were not Patrick's. The nine cases that eventually comprised the evidence against Patrick were selected from a period in which Patrick had performed 2000-2500 surgeries. Of the nine, two were performed while Patrick was still at the Astoria Clinic. The experts at trial disagreed as to the magnitude of Patrick's errors in the nine cases. The jury easily could have concluded that the mishaps in the cases did not justify termination of privileges.

Dr. Boelling chaired the ad hoc committee that heard the charges and the defense. Boelling agreed to serve as chairman despite the fact that he had testified to the BOME against Patrick about some of the cases that were before the committee. Patrick did not learn of this con-

holics Anonymous meetings after his breakdown, he subsequently appeared in the emergency room intoxicated. He did not report himself to the BOME as an impaired physician until he had been attending AA meetings for two years. None of the behavior was ever the subject of peer review proceedings. After he moved to the Clinic building, McLaughlin received the bulk of the orthopedic referrals from the Clinic doctors and was elected Chief of Staff of the hospital.

flict of interest until several months after the proceedings were initiated.

At the hearings, Patrick attempted to show that the peer review process had treated his cases differently from analogous cases of other doctors. The committee was inattentive during his presentation. Patrick's counsel asked the doctors on the committee to testify as to their personal knowledge of the cases discussed as part of the defense and as to their personal biases against Patrick. The committee members refused. Patrick, convinced that the outcome was preordained, and reluctant to allow the revocation of hospital privileges to appear on his record, resigned from the hospital. He then applied for, and was granted, staff privileges at Ocean Beach Hospital.

Patrick filed this suit in early 1981 before the proceedings to terminate his hospital privileges were concluded. He alleged violations of sections 1 and 2 of the Sherman Act and interference with prospective economic advantage under Oregon law. Trial commenced December 3, 1984. The jury returned a verdict against Drs. Russell, Boelling and Harris on the section 1 count, against "The Astoria Clinic" on the section 2 count, and awarded Patrick \$650,000 for the antitrust violations, which the court trebled. The jury also awarded \$20,000 in compensatory and \$90,000 in punitive damages against Boelling, Russell and Harris on the state law claim. The court awarded Patrick \$228,600 in attorney's fees. The Clinic doctors timely appeal.

DISCUSSION

I. Antitrust Claims

Appellants claim that their peer review activities at the hospital and in the BOME were mandated by statute and are exempt from federal antitrust liability under the state action doctrine. The doctrine exempts from the antitrust laws actions by the state such as passage of laws

by the legislature or promulgation of rules by the state Supreme Court acting in its legislative capacity. *Hoover v. Ronwin*, 466 U.S. 558, 567-68 (1984). The doctrine is grounded in the history or language of the Sherman Act, neither of which suggests that the Act was intended as a limit on the actions of a state. See *Parker v. Brown*, 317 U.S. 341, 350-51 (1943).

When the challenged activity is not undertaken directly by the legislature or Supreme Court, but rather is carried out by others pursuant to state authorization, "closer analysis" is required. *Hoover*, 466 U.S. at 568. In such cases, it becomes important to assure that the anticompetitive conduct of the state's representative was contemplated by the state." *Id.* To acquire antitrust immunity, such conduct must be taken pursuant to a clearly articulated and affirmatively expressed state policy and must be subject to active supervision by the state. *Southern Motor Carriers Rate Conference, Inc. v. United States*, 105 S. Ct. 1721, 1727 (1985); see *Hoover*, 466 U.S. at 569; *Llewellyn v. Crothers*, 765 F.2d 769, 773 (9th Cir. 1985).

To demonstrate "clear articulation," the defendants need not point to specific authority for anticompetitive activity; it is enough that they show that the legislature contemplated the kind of activity complained of. *Town of Hallie v. City of Eau Claire*, 105 S. Ct. 1713, 1719 (1985). See *Benson v. Arizona State Board of Dental Examiners*, 673 F.2d 272, 276 n.8 (9th Cir. 1982). That is, it must be clear that the legislature intended to replace competition with regulation in the relevant market. *Southern Motor Carriers*, 105 S. Ct. at 1731.

Oregon's statutory scheme demonstrates such an intent. Oregon requires that its health care facilities be licensed. Or. Rev. Stat. § 441.015(1). To maintain the license, the governing board of each facility must insure that procedures exist for granting or restricting privileges of the medical staff and that the medical staff is organized in

such a manner as effectively to review one another's professional practices at the facility to reduce morbidity and mortality and to improve patient care. Or. Rev. Stat. §§ 441.030, 441.055(3)(c) & (d). Under the Oregon scheme,⁵ consumers are not given unlimited choice as to the physicians they prefer; the hospitals can restrict patients' access to doctors whose performances are determined to be substandard. Moreover, the scheme mandates that other doctors take an active part in the regulation. Thus, peer review constitutes regulation by competitors, especially in a small community such as Astoria or in a very specialized field. See *Marrese v. Interequal, Inc.*, 748 F.2d 373, 388 (7th Cir. 1984), *cert. denied*, 105 S. Ct. 3501 (1985). Compulsion is the best evidence of a state policy. *Southern Motor Carriers*, 105 S. Ct. at 1729; see *Town of Hallie*, 105 S. Ct. at 1720. Oregon, by compelling physicians to review their competitors, affirmatively has expressed a policy to replace pure competition with some regulation.⁶

The peer review process is supervised actively by the state. To maintain licenses, health care facilities regularly must review privilege termination and restriction procedures to assure their conformity to applicable law. Or. Rev. Stat. § 441.030, 441.055(3)(c). When a health care facility terminates or restricts the privileges of a physician, it must promptly report to the BOME all facts and circumstances that caused the termination or restraint. Or. Rev. Stat. § 441.820(1). Supervision by the Board, a state agency, is equivalent to supervision by the state. *Benson*, 673 F.2d at 278. The hospital's decisions

⁵ It is undisputed that the peer review structure at Columbia Memorial was established pursuant to this statutory scheme.

⁶ Oregon also provides good faith immunity to the participants in the peer review process. Or. Rev. Stat. § 41.675(4). One court has held that such immunity alone demonstrates clear articulation. See *Tambone v. Memorial Hospital*, 635 F.Supp. 508, 513 (N.D. Ill. 1986).

terminating or restricting privileges are also judicially reviewable. Oregon courts have reviewed adverse privilege decisions to determine if they were made in good faith pursuant to fair procedures and were supported by the facts. See *Straube v. Emmanuel Lutheran Charity Board*, 278 Or. 375, 600 P.2d 381, 386-87 (1979), *cert. denied*, 445 U.S. 966 (1980); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398, 1401 (1975); see also Or. Rev. Stat. 41.675(5) (rule that peer review proceedings confidential inapplicable in judicial proceedings challenging adverse privilege decision). The combination of internal review by the hospitals, review by the BOME, and review by the courts constitutes adequate supervision. See *Tambone v. Memorial Hospital*, 635 F.Supp. 508, 514-15 (N.D. Ill. 1986) (no state supervision where records of peer review not automatically transmitted to state agencies); see also *Hoover*, 466 U.S. at 572 n.22 (availability of judicial review evidence of state action); cf. *California Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105-06 (1980) (no supervision of state authorized resale price maintenance where no review of reasonableness of price schedules, no monitoring of market conditions or "pointed reexamination" of the program).

The Seventh Circuit, addressing Indiana's scheme, which is nearly identical to Oregon's, has concluded that peer review is exempt from antitrust liability. *Marrese v. Interequal, Inc.*, 748 F.2d 373 (7th Cir. 1984). The court in *Marrese* stated that given the state statutory scheme, "it runs contrary to the very concepts of state sovereignty and federalism for a federal court to review the conduct of a peer review committee, under the guise of the Sherman Act" *Id.* at 395.

Patrick points out that a recent district court case, *Quinn v. Kent General Hospital, Inc.*, 617 F.Supp. 1226 (D. Del. 1985) disagrees with the result reached by *Marrese*. See 617 F.Supp. at 1238-39. The *Quinn* court

found that peer review proceedings, properly applied, do not restrict competition and concluded that the state had not intended to replace competition with regulation by mandating peer review. *Id.* at 1239 & n.10. We disagree. The peer review process allows doctors to agree to eliminate a competitor from the market because they believe his or her product is substandard. An analogous scheme would allow General Motors, Chrysler and Ford to review the safety of Toyotas to determine if the public should be allowed to drive them. Clearly such an arrangement would raise antitrust concerns. The fact that the state's regulations may be wise and in the best interest of consumers does not alter the fact that the regulations limit free competition. See *FTC v. Indiana Federation of Dentists*, 106 S. Ct. 2009, 2020 (1986).

Dr. Russell's activities as a member of the BOME also are exempt from antitrust liability under the state action doctrine. Patrick complains about Russell's actions taken as part of the BOME's consideration of complaints against medical practitioners (Patrick and Weber). Russell gave the Board information about the practitioners, participated in discussion of the case, and drafted a reprimand letter. The BOME is the state agency authorized by the legislature to receive such complaints and to investigate and act on them. Or. Rev. Stat. § 677.265, 677.415. Actions within the scope of a state official's authority, taken pursuant to express state policy, which are contemplated by the statutory scheme, are actions of the state and therefore immune. See *Llewellyn*, 765 F.2d at 774-75; see also *Southern Motor Carriers*, 105 S. Ct. at 1730 (immunity available when state agency's activity taken pursuant to policy approved by state legislature). Russell's activities meet this test.

There was substantial evidence that the defendants acted in bad faith in the hospital's peer review process and in the BOME proceedings. Patrick argues that the state action doctrine does not immunize bad faith con-

duct. This argument misconstrues the nature of the doctrine. Once we have determined that a state has acted to replace competition with regulation in a given market, out of respect for the sovereignty of the state, federal antitrust laws simply are displaced. See *Hoover*, 466 U.S. at 574. The subjective motivations of the individual actors are irrelevant. *Llewellyn*, 765 F.2d at 774; see *Hoover*, 466 U.S. at 581 n.34. Actions otherwise immune do not "forfeit that protection merely because the state's attempted exercise of its own power is imperfect in execution under its own law." *Llewellyn*, 765 F.2d at 774; see *Hoover*, 466 U.S. at 572 n.22 (whether state committee followed applicable state Supreme Court rules irrelevant to applicability of the doctrine); *Sonitrol of Fresno, Inc. v. American Telephone & Telegraph Co.*, 629 F.Supp. 1089, 1097-1100 (D.D.C. 1986) (state action doctrine applies to acts of rate-setting agency despite tactics of deception and misrepresentation of phone companies seeking rate increases). Whether state agents or others acting pursuant to state authorization have acted in bad faith is generally a question for the state courts. See *id.* (quoting Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv. L. Rev. 435, 453 (1981)). "A contrary conclusion would compel the federal courts to intrude upon internal state affairs whenever a plaintiff could present colorable allegations of bad faith on the part of defendants." *Id.*

Patrick cites the statute that immunizes good faith peer review activity to demonstrate that Oregon has authorized only good faith conduct. See Or. Rev. Stat. § 41.675(4). However, we doubt that a state ever authorizes bad faith actions as such, any more than it authorizes errors of fact or law or procedural irregularities. See *Llewellyn*, 765 F.2d at 774; Areeda, 95 Harv. L. Rev. at 450. The fact that Oregon only immunizes good faith conduct demonstrates that Patrick had a state law remedy for any actions against him in bad

faith,⁷ but does not alter the basic fact that the actions challenged in this case were those of the state. *See generally Marrese*, 748 F.2d at 932 (applying state action doctrine despite similar good faith immunity statute).

Because much of the evidence presented in this case related to actions exempt under the state action doctrine, we reverse the judgment on the antitrust claims and remand to the district court to determine if Patrick has actionable antitrust claims remaining based on conduct other than the peer review process.⁸

II. State Law Claim

Appellants argue that we must reverse the judgment on the state law claim because the district court failed to instruct the jury correctly as to various state law immunities.⁹ Dr. Russell, as a member of BOME, is entitled to the same immunity that a judge would receive. Or. Rev. Stat. § 677.335(1). Under Oregon law, judges are immune from personal liability for acts taken in the performance of judicial business unless jurisdiction for their

⁷ We do not decide whether Patrick may have waived any state law remedies by resigning rather than completing the review process and appealing to the Oregon courts.

⁸ Because attorney's fees were awarded to Patrick as prevailing party in an antitrust action, *see* 15 U.S.C. § 15 (1982), we also reverse the grant of fees.

⁹ Patrick contends that appellants did not adequately object to the failure to give their instructions, and so these complaints are not properly before this court. However, the trial court granted continuing objections to instructions not given. Where a trial court is aware of a party's position on any issue and refuses to give an instruction, no further objection is necessary to preserve it for appeal. *See Brown v. Avemco Investment Co.*, 603 F.2d 1367, 1371 (9th Cir. 1979). In this case, the court was aware of the Clinic doctor's position on immunities (the arguments were made in the pretrial brief and in support of motions for directed verdicts), and so the issues are properly before us.

actions is clearly absent.¹⁰ *Utley v. City of Independence*, 240 Or. 384, 402 P.2d 91, 93-93 (1965); *Quast v. City of Ontario*, 43 Or. App. 557, 603 P.2d 1210, 1210-11 (1979); *see Higgins v. Redding*, 34 Or. App. 1029, 580 P.2d 580 (1978). Immunity applies even if the judge's jurisdiction is questionable. *Utley*, 402 P.2d at 92. Dr. Russell's activities as a member of BOME therefore were immune unless jurisdiction was clearly absent. As we have noted, all the actions complained of fell within the scope of his statutory duties and involved questions well within the jurisdiction of the BOME. Thus, the trial court erred by failing to give the requested instruction to the effect that actions undertaken as a member of BOME are immune from state law liability.

Witnesses before the BOME are immune from civil liability under Oregon law for their testimony unless they commit perjury. Or. Rev. Stat. § 677.335(2). The trial court erred in not giving an instruction to reflect that immunity as applied to Drs. Boelling and Harris. Finally, doctors who serve on or communicate information to hospital committees or governing bodies have good faith immunity from civil liability. Or. Rev. Stat. § 41.675(4). The jury was told that the defendants were immune from liability for good faith activities taken before, or as members of the ad hoc committee.¹¹ However, every action on or before any of the numerous committees mentioned in this case was entitled to good faith

¹⁰ Patrick argues that judicial immunity standards from federal civil rights cases should govern. *See, e.g., Stump v. Sparkman*, 435 U.S. 349 (1978). However, the issue is to what extent Oregon has immunized its judges. Oregon's judicial immunity may be different from federal judicial immunity. *See O'Neil v. City of Lake Oswego*, 642 F.2d 367, 368 n.1 (9th Cir. 1981).

¹¹ The court presumably referred to the committee that heard Patrick's defense of his privileges; there were several ad hoc committees mentioned at trial.

immunity. The trial court erred in failing to give defendants' requested instruction making that clear.¹²

To require reversal, error in a civil case must more probably than not have affected the verdict. *Haddad v. Lockheed California Corp.*, 720 F.2d 1454, 1459 (9th Cir. 1983). The judgment against Dr. Russell must be reversed. The most damning evidence against him was the evidence of his duplicity at the BOME; the fact that this conduct was immunized would likely have affected the jury's decision. The case for reversing the judgments against Drs. Harris and Boelling is closer. The jury, by awarding punitive damages against them, found that some of their conduct amounted to "deliberate disregard for the rights of others or reckless indifference to such rights." We believe this equates to a finding of bad faith. Thus, it is unclear how much significance should be attached to the absence of a good faith immunity instruction. However, the court instructed the jury on several theories that might result in liability of the defendants,¹³ making it impossible to say which theory or theories the jury adopted. Moreover, since the verdict form did not require the jury to allocate responsibility for damages to particular defendants or particular conduct, we cannot tell whether or to what extent the jury was influenced by Russell's immunized conduct in

¹² We recognize that we must look at the jury instructions as a whole to determine whether they were adequate. See *Los Angeles Memorial Coliseum Commission v. National Football League*, 726 F.2d 1381, 1398 (9th Cir.), cert. denied, 105 S. Ct. 397 (1984). The instructions as a whole did not give any indication that defendants' conduct (other than that involving the one ad hoc committee) might be immune.

¹³ The court outlined five theories by which the defendants could be liable: refusing to call Patrick when emergency room patients asked for him; failing to refer prospective patients to him; refusing to continue treatment of patients who requested Patrick's surgical services; general interference with Patrick's relationships with individual patients; and causing the loss of his staff privileges.

arriving at its damage figures. The jury was not properly instructed on immunity: to wit, that Boelling and Harris were immune from liability for their testimony before the BOME; that all defendants had qualified immunity as to their conduct pertaining to the various hospital committees; and that Russell had absolute immunity for his conduct as chairman of BOME. Proper instruction with respect to the various immunities would more likely than not have changed either the determination of liability or of damages as to Boelling and Harris. Thus, we reverse the judgments against all three defendants on the state law claim and remand for a new trial.

CONCLUSION

On remand, the district court must determine whether sufficient evidence remains in the case to permit retrial of the antitrust claims. There is no doubt that the evidence, viewed in the light most favorable to Patrick, reveals shabby, unprincipled and unprofessional conduct on the part of the defendants. However, the State of Oregon regulates its health care industry through mandatory peer review and thereby immunizes much of the conduct complained of. The state action doctrine limits Patrick's remedy under the antitrust laws. It does not preclude antitrust liability for anticompetitive conduct outside the peer review process, nor does it preclude resort to state law claims or remedies available in state court.

REVERSED and REMANDED.

OPPOSITION BRIEF

(2)
No. 86-1145

Supreme Court, U.S.
FILED
FEB 17 1987
JOSEPH P. GRANOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1986

TIMOTHY A. PATRICK, M.D.,
Petitioner,
v.

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTELKAMP, M.D.,
PATRICK MEYER, M.D.,
GARY M. BOELLING, M.D.,
ROBERT D. NEIKES, M.D.,
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LEIGH C. DOLIN, M.D.,
RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
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Respondents.

BRIEF IN OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI TO THE
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QUESTIONS PRESENTED FOR REVIEW

1. Whether hospital-based peer review is pursuant to a clearly articulated policy of and is actively supervised by the State of Oregon.

2. Whether there is a clearly articulated policy of the State of Oregon requiring one of its agencies, the Board of Medical Examiners, to replace competition with regulations in regard to licensing, disciplining and/or revoking a physician's privilege to practice medicine?

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1986

NO. 86 - 1145

Timothy A. Patrick, M.D.
Petitioner,

v.

William M. Burget, M.D.,
Jorma M. Leinassar, M.D.,
R. G. Kettelkamp, M.D.,
Patrick Meyer, M.D.,
Gary M. Boelling, M.D.,
Robert D. Neikes, M.D.,
Franklin D. Russell, M.D.,
Leigh C. Dolin, M.D.,
Richard C. Harris, M.D.,
Daniel M. Rappaport, M.D.,
and Tzu Sung Chiang, M.D.,
doing business as Astoria Clinic,
Respondents.

BRIEF IN OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SUPPLEMENTAL STATEMENT OF STATUTES

INVOLVED IN THIS CASE

(set forth verbatim in the Appendix)

Or. Rev. Stat. §§ 677.015, 677.095, 677.190-.208, 677.235-.275, 677.280, 677.320-.335, 677.415-.435.

Or. Rev. Stat. §§ 431.110-.120, 431.140-.170, 431.190.

Or. Rev. Stat. §§ 441.015, 441.022-.055, 441.705-.715, 441.820.

Or. Rev. Stat. § 244.120.

STATEMENT OF THE CASE

There is a temptation to make a point-by-point refutation of the petitioner's statement of facts. This temptation will be withstood but with the clear recognition of our disagreement. Rather, the statement of facts will be supplemented in order to place the questions tendered for review in the appropriate context.

A.

Peer Review by the Board of Medical
Examiners of the State of Oregon

The Board of Medical Examiners (BOME) is a state agency (App. 37-39). Its members are selected by the Governor and these nominations are ratified by the Senate. It has complete regulatory authority over the practice of medicine in Oregon. Practitioners and health care facilities are compelled to report to the BOME if the practice of any physician is "or may be" not competent or in keeping with the ethical standards of the profession. The BOME has authority, subject to judicial review, to discipline or revoke the privilege of a doctor to practice within the State.

On November 15, 1979, the Executive Committee of the medical staff of the Columbia Memorial Hospital referred

Dr. Patrick's handling of the Willie case (issue of patient abandonment) to the BOME (Ex. 1130, Tr. 2231).

The BOME subsequently subpoenaed the Willie patient charts, as well as others, from the Hospital for review (Tr. 2422).

On January 2, 1980 Dr. Patrick and his associate, Dr. Weber, were interviewed by the Investigative Committee of the BOME (Tr. 714). On January 10, 1980 the BOME received a preliminary report from Dr. Russell, Chairman of the Investigative Committee (Tr. 1160). He stated that there were two issues before the BOME for consideration. The first was behavior in dealing with Willie; and the second was "possible incompetence, malpractice or unprofessional behavior with other cases." He advised that the report from the consultants had not yet been received. He further stated, for the record, pursuant to

Or. Rev. Stat. § 244.120 (App. 1), that he might have a potential conflict of interest because both he and Dr. Patrick, eight years previously, had been employed by the Astoria Clinic; and both were members of the same community and of the same medical staff (Tr. 745). In consequence, he recused himself from voting but not from participation in deliberations.

At the meeting on January 10 Dr. Patrick was asked to explain the treatment given Willie. Abandonment of the patient was admitted which may have influenced the outcome of the treatment (Ex. 1160).

After this meeting the Investigative Committee interviewed five physicians and two non-physicians. For example, Dr. Stull testified that Dr. Patrick had abandoned patients after performing major elective surgery; performed surgery outside

his field of competence; and failed to obtain timely consultations (Tr. 2344-56). Dr. Simmons reported patient abandonment; performance of procedures on asymptomatic patients; handling of cases more appropriately treated in better equipped hospitals; misdiagnoses; and technical errors (Ex. 1149).

Two outside consultants were retained by the BOME. Dr. Battalia concluded that there were three cases representing "abandonment with poor judgment in operating and then leaving town"; that several cases should have been transferred to a tertiary hospital rather than attempting to perform complicated surgery in a secondary hospital; and that it was doubtful that there were sufficient thoracic and vascular cases in Astoria to permit retention of expertise and thus such

cases should be transferred elsewhere (Ex. 442; Tr. 1075).

The second consultant, Dr. Hugh Lawrence, advised the BOME that Dr. Patrick's charts present

"* * * significant and real deficiencies in the pathology notes, autopsy reports, operative notes, and progress notes which make an analysis of patient care deficiencies difficult if not impossible."

(Ex. 174, Tr. 1033)

At its April 12, 1980 meeting the BOME unanimously voted, with Dr. Russell abstaining (Tr. 744), to send a letter of reprimand and constructive criticism to Dr. Patrick (Ex. 49, Tr. 999, 1085, 1089).

The reprimand letter stated that 15 charts had been reviewed and that they raised serious concern about abandonment of Willie, need to obtain earlier consultations, scope of his surgical privileges, staff relations, and maintenance of

appropriate vascular and thoracic competence. It concluded by stating that the BOME reprimanded him with respect to the Willie case and that it hoped that Dr. Patrick would take its comments seriously and make significant change in his conduct (Ex. 51).

On May 13, 1980 Dr. Patrick admitted the appropriateness of the reprimand with respect to the Willie case but questioned reference to 14 other charts because he had not been granted an opportunity to review and discuss these. On June 6, 1980 the BOME released the names of the additional patients to Dr. Patrick for his review (Ex. 55).

On August 12, 1980, the BOME held a conference. Its Chairman, Dr. Tanaka, stated that Dr. Patrick had objected to the portions of the reprimand letter that related to subjects other than Willie

(Ex. 1229) and that he had demanded that the BOME form an independent Ad Hoc Committee to review these cases. He further advised that Dr. Patrick threatened legal action if this were not done.

Dr. Russell responded by relating: the letter the BOME sent reprimanded Dr. Patrick solely for the Willie case; that the balance of the letter was not based merely upon 15 charts but interviews with five physicians and two non-physicians plus other information gathered by the investigator; and that it would not be possible to form an independent ad hoc committee without violating the statutory witness privilege. He further opined that the balance of the letter was simply advice given which Dr. Patrick could accept or disregard but that if he felt aggrieved, judicial review was available. In conclusion, Dr. Tanaka suggested meeting

with Dr. Patrick and the board consultant, Dr. Battalia and if it could be accomplished, without revealing confidences, to go over the charts for educational purposes. This proposal was adopted (Exs. 1229, 1231). The meeting was held on September 2, 1980 between Drs. Patrick, Tanaka, Battalia, and Mr. Marmaduke, Dr. Patrick's legal counsel. Each chart was reviewed. It was concluded that two or three of these charts, in addition to the Willie matter, deserved criticism.

On October 11, 1980 a final meeting of the BOME was conducted. Dr. Tanaka reported his conclusions and stated that in some instances where the charts were the sole basis for the letter that there may have been an overstatement; but that there appeared to be judgmental areas of concern with Dr. Patrick: a sparsity of formal consultation, egotism, and performance of

specialty procedures inappropriate to a rural community (Tr. 1009).

At the conclusion of its meeting, the BOME unanimously declined to modify its reprimand letter (Ex. 170; Tr. 1013-1014). In response, Dr. Patrick filed a Petition for judicial review of the agency determination, as well as a civil claim for damages against the BOME. In December, 1981 the BOME withdrew its reprimand letter, notwithstanding Dr. Patrick's concession of its validity as applied to Willie; but further advised that the BOME would continue its investigation of Dr. Patrick's practice.

B.

Hospital-Based Peer Review Proceedings

In November, 1981 Dr. Patrick performed the second of two unwarranted surgeries on a 15 year old boy, Stuart Snodgrass. No doctor defended his treat-

ment of this patient (Tr. 247, 756, 823, 2142, 2279-2287, 2357; Ex. 1280).

Request was made of the Executive Committee to take corrective action based upon this case and numerous prior incidents (Ex. 1274).

An Investigatory Committee was established which conducted interviews of nurses and doctors, including Dr. Patrick. It also reviewed substantial historical matters pertaining to the practice of Dr. Patrick (Exs. 1276, 1280-1281). The Committee found that corrective action was warranted. It forwarded its recommendation to the Executive Committee (Tr. 2517; Ex. 1289) which, after granting Dr. Patrick an opportunity to be heard,¹ adopted the recommendation.

¹He claimed his only mistake on the Snodgrass case was "being caught" (Tr. 2518).

Pursuant to the Bylaws, Dr. Patrick requested a hearing. A Hearing Ad Hoc Committee was appointed. Such a Committee, under the Bylaws, had authority to recommend confirmation, rejection or modification of the Executive Committee resolution (Ex. 156).

A panel was selected. Dr. Patrick objected to most of the participants. His objections were motivated, in part, by a desire to prevent the Ad Hoc Committee from being formed (Tr. 556). Legal counsel to the Executive Committee responded to these objections. His opinion was communicated to special counsel to the Ad Hoc Committee and was adopted by the Committee.

The hearing commenced on November 23, 1981 (Tr. 1192). It lasted 17 sessions; something in excess of 60 hours. At the 17th session Dr. Patrick proclaimed that he felt the panel was biased against him and

tendered his resignation from the Hospital staff. In consequence, the proceedings were adjourned.

Under the Bylaws of the Medical Staff any recommendation from the Ad Hoc Committee must be approved by the Board of Trustees (Ex. 156). There was no evidence that members of the Board of Trustees held any bias against Dr. Patrick. There was substantial contrary evidence (Tr. 607-609, 2188-2190; Ex. 1315).

Strict procedures governed appeal to the Trustees (Section 6(E), (G) of Ex. 156). Under these rules Dr. Patrick had the right to raise the following:

1. Whether, as a procedural matter, the panel members were biased; and
2. Whether the evidence adduced at hearing warranted any form of corrective action.

No evidence was adduced that the Trustees would have ignored these requirements. It is thus unknown how the Board of Trustees would have dealt with an appeal to it (Ex. 156). Finally, judicial and agency review was available under state law of a Trustee decision had Dr. Patrick required or sought it. This was not done.

ARGUMENT

IN OPPOSITION TO ALLOWANCE

OF A WRIT OF CERTIORARI

U.S. Sup. Ct. Rule 17 establishes guidelines for this Court to exercise its judicial discretion for review on Petition for Writ of Certiorari. Petitioner does not assert a conflict between the Circuits; nor a conflict between a decision of this Court and the lower court. He does assert that an important question involving interpretation of Oregon statutory and common law exists and that the issues

tendered are important to the parties. This is not the standard upon which the Court exercises its discretion. Rice v. Sioux City Memorial Park Cemetery, 75 S. Ct. 614, 349 U.S. 70 (1955).

A.

The Issues Presented by This Case Involve Application of Settled Questions of Federal Law and Interpretation of the Statutory and Common Law of the State of Oregon

— Peer review is a process by which a hospital determines which physicians shall be admitted to practice in a hospital; the scope of credentials of a physician within the hospital; and the right to retain staff privileges. The process is monitored and supervised by the BOME (which has the prerogative to suspend, discipline or revoke a physician's license) and by the Health Division of the State of Oregon. As

peer review has evolved in this country, it is, at least, a spiritual descendent of the early practice of seeking out jurors who personally had knowledge of the facts of a case. See T. Plunkett, A Concise History of the Common Law, 131 (5th Ed. 1956); Thayer, The Jury and Its Development, 5 Harvard Law Review 249, 297 (1892).

Peer review necessarily has a regulatory impact upon competition among physicians inter se. As conceded by petitioner:

"* * * The peer review process therefore permits one group of competitors to exclude another competitor from an essential facility, and therefore the market * * *" (Pet. Br. 7).

Its components are both constructive criticism and withdrawal of privileges for those who do not appropriately respond.

The Ninth Circuit in this case applied

the following state action litmus tests previously enunciated by this Court:

1. State action shelters private parties from anti-competitive conduct providing:

a. Their conduct is pursuant to clearly-articulated state policy; and

b. There is active state supervision, Southern Motor Carriers Rate Conference v. United States, 105 S. Ct. 1721, 471 U.S. ____ (1985) except where a state agency, such as the BOME, imposes the restraint.

2. Satisfaction of the two prong test requires careful analysis of state law; and

3. The presence of evidence of subjective bad faith is immaterial. Hoover v. Ronwin, 104 S. Ct. 1989, fn. 34, 466 U.S. 558 (1985).

Petitioner's quarrel is limited to the Ninth Circuit's construction of Oregon law, although he attempts to cast his claim on a much broader basis (Pet. Br. 7-8). However, to determine whether the Ninth Circuit's decision has application in any state other than Oregon requires a painstaking analysis of every state's statutory and common law. It is certain that the lower court's decision is thus limited to the conduct of peer review by private parties within the state of Oregon.

Petitioner is correct that this case attracted national attention. There was shock within the medical community that a massive verdict could be entered against physicians engaging in peer review, particularly in the wake of the Seventh Circuit decision in Maresse v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. den., 105 S. Ct. 3501 (1985). The visage

of the verdict quelled effective peer review. A hue and cry arose for congressional remedial action. This resulted in passage of the Health Care Quality Improvement Act of 1986, Title IV, (Encouraging Good Faith Professional Review Activities) of the State Comprehensive Mental Health Services Plan Act of 1986, Public Law Number 99-660. Some members of Congress objected to passage of the statute because the Ninth Circuit correctly decided this case. Representative Edwards stated:

"The Ninth Circuit, in agreeing with both the Seventh and Third Circuits, found that peer review received the cloak of protection from the state action doctrine, because the state had a clear policy to displace competition in the certification and regulation of hospital health care. Such state involvement would defeat all potential antitrust claims by private parties. Adding a statutory exemption would thus be a gratuitous exercise, with the only result that a dangerous precedent would be set for other

groups seeking a special treatment." 132 Cong. Rec. H 9961, Daily Edition, October 14, 1986 (statement of Representative Edwards).

Representative Waxman, less certain of the clarity of the law, argued that if this case were modified, a new statutory scheme was necessary. If left unchanged the immunity granted by HR-5540 would be irrelevant in some states. 132 Cong. Rec. H 11590 (Daily Edition October 17, 1986) (statement of Representative Waxman). The resulting law grants immunity for engaging in peer review, where reasonable cause exists for same, under both federal and state law. The state law exemption is, however, predicated upon recognition of a federalism principle permitting the state to make its own choice. The uncertainty expressed by Representative Waxman appears to be limited to whether this Court has previously extended the state action

doctrine to instances where there was some evidence of subjective bad faith. Representative Waxman was in error; this Court has conclusively resolved this issue. See Hoover v. Ronwin, 466 U.S. 558, 104 S. Ct. 1989, 1998 (1984). See also Llewellyn v. Crothers, 765 F.2d 769, 774 (9th Cir. 1985); Areeda, Antitrust Immunity for "State Action" after Lafayette, 95 Harvard Law Review, 435, 453 (1981).

A grant of certiorari would create confusion and uncertainty. It would leave open to question until final decision whether the Seventh and Ninth Circuits had correctly decided questions of state law; might cause dislocation in states which may have similar statutes; and would quell peer review during the pendency of proceedings here.

B.

The Decision Below Is Justified
by the State Action Doctrine.

In a series of cases commencing with Parker v. Brown, 317 U.S. 341, 63 S. Ct. 307 (1943), this Court precisely crafted the parameters and detail of the state action doctrine.²

Two discrete tests have been stated. To immunize private actors there must be a demonstration that:

1. The challenged restraint is one clearly articulated and affirmatively expressed as state policy; and

²California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980); Community Communications Co. v. City of Boulder, 455 U.S. 40, 102 S. Ct. 835 (1982); Hoover v. Ronwin, 466 U.S. 558, 104 S. Ct. 1989 (1984); Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 98 S. Ct. 1123 (1978) Southern Motor Carriers Rate Conference v. United States, 471 U.S. ___, 105 S. Ct. 1721 (1985); and Town of Hallie v. City of Eau Claire, 471 U.S. 34, 105 S. Ct. 1713 (1985).

2. The policy is actively supervised by the state³ itself.

1.

The Court of Appeals correctly construed state law to satisfy the first prong of the state action doctrine, as applied to hospital-based peer review, i.e., that the restraint be clearly articulated and affirmatively expressed as state policy.

(a)

The Court of Appeals correctly interpreted state policy.

In Astoria, Dr. Patrick was one of three practicing general surgeons. Removal of his staff privileges would necessarily create a temporary anti-competitive effect as it would reduce the number of physicians

³With respect to public actors, such as the BOME, only the first test need be satisfied. Town of Hallie v. City of Eau Claire, supra.

competing for provision of health care services to the public.⁴

To satisfy the "clear articulation" test, it is not necessary to point to specific authority for anti-competitive activity; it is sufficient if it is demonstrated that the Legislature contemplated the kind of activity complained of. Town of Hallie v. City of Eau Claire, 471 U.S. 34, 105 S. Ct. 1713, 1719 (1985). In other words, it must be clear that the Legislature intended to replace unfettered competition with regulation in the relevant market. Southern Motor Carriers Rate Conference v. United States, 471 U.S. ___, 105 S. Ct. at 1731 (1985). Here that means discipline

⁴The word "temporary" is used advisedly. There was no showing of barriers to access to a new surgeon who might choose to fill the void created by Dr. Patrick's absence.

or removal of staff privileges for conduct perceived to be lower than professional expectations.

The Ninth Circuit correctly held, after exhaustive scrutiny of the Oregon statutory scheme, such legislative intent exists (Pet. App. 9a). All Oregon health care facilities must be licensed, Or. Rev. Stat. § 441.015(1). Retention of license by a hospital is conditioned upon the governing board of a hospital mandating procedures for granting or restricting privileges of medical staff. Such procedures must be regularly reviewed to assure conformity to law, and the staff must be organized in such a fashion as to effectively "review each other's professional practice" at the facility. Or. Rev. Stat. § 441.030, 441.055(3)(c) and (d) (App. 14-17). Under this statutory scheme, patients are not granted free

choice of the physician they prefer, and hospitals are required to restrict patient access to doctors who have attained appropriate credentials and whose continuing standards of care satisfy the community norm. The Oregon Legislature compels review by physicians of their competitors and thus has affirmatively expressed a policy to replace free competition for medical staff positions with regulation.

Petitioner appears to concede the legislative intent to supplant competition with regulation.⁵ Rather, he asserts, without citation of any authority, that whenever there is some evidence of subjective bad faith the clearly-articulated standard has not been satisfied. The assertion proves too much.

⁵See Pet. Br. p. 7.

First, it ignores the second prong of this Court's test. Active supervision is intended to cure nonconformance. Second, it creates the specter of exhaustive and expensive litigation whenever an issue of good faith is raised, thus quelling interest in any form of peer review. Will a doctor engage in peer review if it is known that a jury would be permitted to pass on his subjective good faith? Third, it contradicts this Court's prior determination, as well as the well-reasoned decision of the Ninth Circuit in Llewellyn v. Crothers, supra. Hoover v. Ronwin, supra. Finally, it would, for all practical purposes, make the state action doctrine a nullity.

(b)

The opinion is consistent with the well-reasoned decision from the Seventh Circuit.

In Maresse v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. den. 105 S. Ct. 3501 (1985) the plaintiff alleged that the exclusion of Dr. Maresse from the medical staff of the hospital was accomplished through bad faith performance of peer review. The issue presented in this case is thus identical. This Court properly exercised its discretion to refuse certiorari in Maresse and should do so here.

Petitioner asserts the remarkable position that a conflict between the only circuits⁶ to consider these issues on the one hand and two contrary district court decisions on the other constitutes a ground for certiorari. Of course conflict between

⁶The Fourth Circuit also has held that peer review satisfies the first prong of the state action test. Coastal Neuro-Psychiatric Assn. v. Onslow Mem. Hosp., Trade Reg. Rptr. CCH ¶ 67,156 (4th Cir. 1986).

circuit courts and district courts is not, under U.S. Sup. Ct. Rule 17, a ground for the grant of certiorari.⁷

⁷Both Quinn v. Kent General Hospital, Inc., 617 F. Supp. 1226 (D.C. Del. 1985) and Posner v. Lankenau Hospital, Trade Reg. Rptr. CCH ¶ 67,351 (E.D. Pa. 1986) were incorrectly decided. While recognizing that the state statutes under review imposed a regulatory scheme, each concluded that there was no evidence of a legislative intent to supplant competition with regulation. Putting to the side the relevance of the differences of the statutory scheme in Oregon as opposed to Delaware and Pennsylvania, there is no question these decisions do violence to concepts of federalism which constitute the underpinnings of the state action doctrine. Where it is the intent of the state to permit private actors to regulate market access and egress, subject to its supervision and control, imposition of the antitrust laws frustrates enforcement of salutary state policy. As the Ninth Circuit correctly states:

"* * * The peer review process allows doctors to agree to eliminate a competitor from the market because they believe his or her product is substandard * * *." (Pet. App. 12a).

Once it is determined that it was the intent of the Legislature to require this type of peer review process, the first

2.

The Court of Appeals correctly construed Oregon statutory and common law to require active review of hospital-based peer review.

The second prong of this Court's litmus test to demonstrate the presence of state action is that the state has the right to actively supervise conduct of private parties. The Ninth Circuit correctly construed Oregon law to require such supervision.

A complex review procedure is required of hospitals. Or. Rev. Stat. § 441.055(3) (App. 15-17). Such procedure must conform to Oregon law. Once the process is complete, a report of any adverse findings pertaining to a physician's privileges at a hospital must be reported to the BOME. Or.

prong of the state action test must be deemed satisfied.

Rev. Stat. § 441.820(1) (App. 23). This notice triggers review by the BOME. Or. Rev. Stat. § 677.415(3) (App. 46-47). Further, Oregon courts review adverse privilege decisions to determine whether they were made in good faith pursuant to fair procedures and supported by the facts. See Straube v. Emanuel Lutheran Charity Board, 287 Or. 375, 600 P.2d 381, 386-87 (1979), cert. den. 445 U.S. 966, 100 S. Ct. 1657 (1980); Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398, 1401 (1975). In this process both the BOME and the state courts are authorized to actively supervise both the procedure and the substance of hospital-based peer review.

In addition, the Health Division of the State of Oregon has specific responsibility to supervise and monitor hospital-based peer review. The hospital-based process is compelled by

state law. A hospital must review privilege termination and restriction procedures to assure their conformance to applicable law, Or. Rev. Stat. § 441.030, 441.055(3)(c) (App. 14-17). Full and fair peer review within each health care facility is compelled.

The Health Division has direct supervision over all matters relating to the preservation of life and health (Or. Rev. Stat. § 431.110(1)) and the enforcement of state health policies and rules (Or. Rev. Stat. § 431.120(2)). It has authority to promulgate rules which have the force and effect of law (Or. Rev. Stat. § 431.140). It is charged, through local health administrators, with the "strict and thorough enforcement of the public health laws of the state in their districts," and must immediately report any violation of law coming to its notice by

observation or upon complaint (Or. Rev. Stat. § 431.150(1)). It has authority to investigate all cases of irregularity or violation of law subject to its jurisdiction (Or. Rev. Stat. § 431.150(3)); and enforcement powers through injunction and/or other proceedings (Or. Rev. Stat. § 431.150(5), Or. Rev. Stat. § 431.155). This body of substantive law thus vests the Health Division of the State of Oregon with authority to investigate compliance with the peer review statutes, Or. Rev. Stat. § 441.055(3), and to obtain compliance upon pain of loss of license or civil penalty (Or. Rev. Stat. § 441.030, Or. Rev. Stat. § 441.705-715) (App. 14, 17-23).⁸

Oregon law grants a corrective process through the Health Division and the BOME to

⁸This process contemplates the right of a physician who feels aggrieved by the peer review process to file a complaint for administrative relief.

assure compliance with the strictures of state law. As a final protection, if the process or substance suggests, judicial review is available. Thus two state agencies and the state courts are vested with full supervisory authority to monitor hospital-based peer review.

Concepts of federalism make it appropriate for antitrust laws to defer to a state's application of its policies and procedure for regulation of hospital peer review. Under Oregon law an aggrieved doctor is thus not deprived of substantive state law remedies, but is foreclosed from seeking federal remedies which do violence to the privileges, immunities, and substantive rights otherwise accorded by state law. See Or. Rev. Stat. § 41.675.

3.

The State of Oregon has a clearly articulated policy requiring one of its

agencies, the BOME, to replace competition with regulation in regard to licensing, disciplining or revoking a physician's privileges to practice medicine.

The BOME has authority to license, discipline and revoke the privilege of a physician to practice in Oregon. Or. Rev. Stat. § 677.190; Or. Rev. Stat. § 677.208; Or. Rev. Stat. § 677.415-.420 (App. 25-30, 36-37, 46-49).

The agency is thus vested with statutory authority to displace unfettered market competition with regulation. The decision to reprimand Dr. Patrick falls squarely within this grant of authority. As such, the state action doctrine grants shelter from imposition of the antitrust laws upon this regulatory scheme.⁹ New

⁹Allegations of bad faith do not detract from this conclusion. Hoover v. Ronwin, 104 S. Ct. 1989, fn. 34, 466 U.S. 558 (1984); Llewellyn v. Crothers, 765 F.2d

Motor Vehicle Board of California v. Orrin W. Fox Co., 99 S. Ct. 403, 412, 439 U.S. 96 (1978), Town of Hallie v. City of Eau Claire, 105 S. Ct. 1713, 471 U.S. 34 (1985); Brazil v. Arkansas Board of Dental Examiners, 593 F. Supp. 1354 (D.C. Ark. 1984), aff. per curiam, 759 F.2d 674 (8th Cir. 1986); Coastal Neuro-Psychiatric Assn. v. Onslow Mem. Hosp., supra.

Petitioner does not seriously question that actions of the BOME, and its members, are generally exempt from antitrust scrutiny under the state action doctrine (Pet. Br., p. 19). Rather, petitioner contends that evidence of anticompetitive actions by the BOME or its members in the course of their deliberation is admissible to support his claim of bad faith peer review in a different forum so long as he

764, 774 (9th Cir. 1985).

does not assert injury from the exempt proceedings. There are numerous conclusive responses to this contention. First, it was not raised before the Ninth Circuit. Petitioner is therefore foreclosed from making such assertion before this Court.¹⁰ Second, if such were the rule, it would implicate the same principles of federalism that constitute the underpinnings of the state action doctrine. Town of Hallie v. City of Eau Claire, supra. For example, it might permit a federal court, under Rule 501 F.R.E., to override state statutes protecting confidentially Or. Rev. Stat. § 677.425(1), Robinson v. Magovern, 521 F. Supp. 842, 907 (W.D. Pa. 1979); and it would chill the vigor of review by the state agency if its proceedings were to be

¹⁰Ellis v. Dixon, 75 S. Ct. 850, 349 U.S. 458, 99 L. Ed. 1231, reh'g denied, 76 S. Ct. 37, 350 U.S. 855, 100 L. Ed. 759.

admitted as proof in federal proceedings on the subjective issue of motive. It would disregard the statutory rights of corrective judicial review by state courts.

For each of the reasons stated, this Court should refrain from review of this issue.

CONCLUSION

The Court of Appeals' opinion, consistent with the Seventh Circuit decision in Maresse, delegates to the states enforcement of peer review standards without intervention of federal antitrust law. As such it gives proper perspective to principles of federalism; is not inconsistent with the intent of Congress; and breathes continuing life into vigorous

peer review. Respondents pray that the
Court deny grant of the writ

Respectfully submitted,

SCHWABE, WILLIAMSON, WYATT,
MOORE & ROBERTS

By: _____
Thomas M. Triplett
Attorneys for Respondents

APPENDIX

App-1

RELEVANT PROVISIONS OF
OREGON REVISED STATUTES

DECLARATION OF POTENTIAL CONFLICTS

244.120 Methods of handling potential conflicts. (1) When involved in a potential conflict of interest, a public official shall:

(a) If the public official is an elected public official, other than a member of the Legislative Assembly, or an appointed public official serving on a board or commission, announce publicly the nature of the potential conflict prior to taking any official action thereon.

(b) If the public official is a member of the Legislative Assembly, announce publicly, pursuant to rules of the house of which the public official is a member, the nature of the potential

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conflict prior to voting, either on the floor or in committee, on the issue giving rise to the potential conflict.

(c) If the public official is a judge, remove the judge from the case giving rise to the conflict or advise the parties of the nature of the conflict.

(d) If the public official is any other appointed official subject to this chapter, notify in writing the person who appointed the public official to office of the nature of the potential conflict, and request that the appointing authority dispose of the matter giving rise to the potential conflict. Upon receipt of the request, the appointing authority shall designate within a reasonable time an alternate to dispose of the matter, or shall direct the official to dispose of the matter in a manner specified by the appointing authority.

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(2) Nothing in subsection (1) of this section requires any public official to announce a potential conflict of interest more than once on the occasion which the matter out of which the potential conflict arises is discussed or debated.

ENFORCEMENT OF HEALTH LAWS

AND RULES

431.110 General powers of Health Division. The Health Division shall:

(1) Have direct supervision of all matters relating to the preservation of life and health of the people of the state.

(2) Keep vital statistics and other health related statistics of the state.

(3) - Make sanitary surveys and investigations and inquiries respecting the causes and prevention of diseases, especially of epidemics.

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(4) Investigate, conduct hearings and issue findings in connection with annexations proposed by cities as provided in ORS 222.840 to 222.915.

(5) Have full power in control of all communicable diseases.

(6) Have authority to send representatives of the division to any part of the state when deemed necessary.

(7) From time to time, publish and distribute to the public in such form as the division determines, such information as in its judgment may be useful in carrying on the work or purposes for which the division was established. [Amended by 1955 c.105 §1; 1967 c.624 §18; 1971 c.650 §9; 1977 c.582 §8).

431.120 Duties of Health Division.

The Health Division shall:

(1) Enforce state health policies and rules.

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(2) Have the custody of all books, papers, documents and other property belonging to the State Health Commission, which may be deposited in the division's office.

(3) Give such instructions as may be necessary, and forward them to the various local public health administrators throughout the state.

(4) Routinely conduct epidemiological investigations for each case of sudden infant death syndrome, including, but not limited to, the identification of risk factors such as birth weight, maternal age, prenatal care, history of apnea and socioeconomic characteristics. The division may conduct such investigations through local health departments only upon adoption by rule of a uniform epidemiological data collection method.

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431.140 Effect of rules. (1) All rules of the Health Division shall have the force and effect of law.

(2) All state and local officers and employees, including peace officers, shall enforce such rules subject to the authority of the Assistant Director for Health.

431.150 Enforcement of health laws generally. (1) The local public health administrators are charged with the strict and thorough enforcement of the public health laws of this state in their districts, under the supervision and direction of the Health Division. They shall make an immediate report to the division of any violation of such laws coming to their notice by observation, or upon complaint of any person, or otherwise.

(2) The Health Division is charged with the thorough and efficient execution of the public health laws of this state in

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every part of the state, and with supervisory powers over all local public health administrators, to the end that all the requirements are complied with.

(3) The Health Division may investigate cases of irregularity or violation of law. All local public health administrators shall aid the division, upon request, in such investigation.

(4) When any case of violation of public health laws of this state is reported to any district attorney or official acting in said capacity, such official shall forthwith initiate and promptly follow up the necessary proceedings against the parties responsible for the alleged violations of law.

(5) Upon request of the Health Division, the Attorney General shall likewise assist in the enforcement of the public health laws of this state.

431.155 Restraining violation of public health laws. (1) Whenever it appears to the Health Division that any person is engaged or about to engage in any acts or practices which constitute a violation of any statute administered by the division or its assistant director, or any rule or order issued thereunder, the division may institute proceedings in the circuit courts to enforce obedience thereto by injunction or by other processes, mandatory or otherwise, restraining such person, or its officers, agents, employees and representatives from further violation of such statute, rule or order, and enjoining upon them obedience thereto.

(2) The provisions of this section are in addition to and not in substitution of any other enforcement provisions contained in any statute administered by

the Health Department or its assistant director.

431.157 County authority to restrain violation of public health laws. Pursuant to ORS 448.100(1), 446.425(1), and 624.510(1), the county is delegated the authority granted to the Assistant Director of Health in ORS 431.155. [1983 c.370 §4]

431.160 Jurisdiction and commencement of prosecutions. (1) District courts have concurrent jurisdiction with the circuit courts of all prosecutions arising under public health statutes.

(2) The district attorney, county attorney or Attorney General may institute prosecutions for violation of any public health statute by information, by indictment or by complaint verified before any magistrate.

431.170 Enforcing health laws and rules when local officers are delinquent.

(1) The Assistant Director for Health shall take direct charge of the functions that are necessary to preserve the public health in any county or district whenever any county or district official fails or refuses to administer or enforce the public health laws or rules which the Assistant Director for Health, the department of the assistant director or board is charged to enforce.

(2) The Assistant Director for Health may call to the aid of the assistant director such assistance as is necessary for the enforcement of such statutes and rules, the expense of which shall be borne by the county or district treasury upon vouchers properly certified by the Assistant Director for Health.

However, sanitary laws and rules must be complied with. [Amended 1977 c.582 §15]

431.190 Advisory board of health care professions; duties; purpose of board rules.

The Assistant Director for Health shall appoint, not later than 60 days after October 4, 1977, an advisory board under ORS 431.325 to study the practices and procedures of the health care professions in this state and to recommend rules relating to the auditing of health care practices in hospitals which will:

(1) Promote standard record keeping by hospitals and persons practicing any healing arts in hospitals;

(2) Establish those criteria most appropriate for determining the proper objects of such auditing; and

(3) Insure auditing of those practices and procedures most relevant to the causes and occurrence of professional negligence in hospitals. [1977 c.448 §8]

441.015 Licensing of facilities and health maintenance organizations; time for compliance with rules and standards.

(1) After July 1, 1947, no person or governmental unit, acting jointly or severally with any other person or governmental unit, shall establish, maintain, manage or operate a health care facility or health maintenance organization, as defined in ORS 442.015, in this state without a license.

(2) Any health care facility or health maintenance organization which is in operation at the time of promulgation of any applicable rules or minimum standards under ORS 441.055 or 731.072 shall be given a reasonable length of time within which to comply with such rules or minimum standards.

441.022 Factors to be considered in licensing. In determining whether to

license a health care facility pursuant to ORS 441.025, the division shall consider only factors relating to the health and safety of individuals to be cared for therein and shall not consider whether the health care facility is or will be a governmental, charitable or other nonprofit institution or whether it is or will be an institution for profit.

441.025 License issuance; renewal; disclosure; transfer; posting. (1) Upon receipt of an application and the license fee, the division shall issue a license if it finds that the applicant and health care facility comply with ORS 441.015 to 441.063, 441.085, 441.087, 442.320, and 442.340 and the rules of the division provided that it does not receive within the time specified a certificate of noncompliance issued by the State Fire

Marshal, deputy or approved authority pursuant to ORS 479.215.

(2) Each license, unless sooner suspended or revoked, shall be renewable annually for the calendar year upon payment of the fee, provided that a certificate of noncompliance has not been issued by the State Fire Marshal, deputy or approved authority pursuant to ORS 479.215.

441.030

* * * * *

(2) The division may deny, suspend or revoke a license in any case where it finds that there has been a substantial failure to comply with ORS 441.015 to 441.063, 441.085, 441.990(3), 442.320, 442.340 or the rules or minimum standards promulgated under those statutes.

441.037 Hearings; procedures; judicial review of rules and orders. (1) When the division proposes to refuse to issue or

renew a license, or proposes to revoke or suspend a license, opportunity for hearing shall be accorded as provided in ORS 183.310 to 183.550.

(2) Promulgation or rules, conduct of hearings, issuance of orders and judicial review of rules and orders shall be in accordance with ORS 183.310 to 183.550.

441.055 Rules; evidence of compliance; health care facilities to insure compliance. (1) The division shall adopt such rules with respect to the different types of health care facilities as may be designed to further the accomplishment of the purposes of ORS 441.015 to 441.087. No rules shall require any specific food so long as the necessary nutritional food elements are present.

(2) Rules describing care given in health care facilities shall include, but not be limited to, standards of patient

care or patient safety, adequate professional staff organizations, training of staff for whom no other state regulation exists, suitable delineation of professional privileges and adequate staff analyses of clinical records. The division may in its discretion accept certificates by the Joint Commission on Accreditation of Hospitals or the Committee on Hospitals of the American Osteopathic Association as evidence of compliance with acceptable standards.

(3) The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility. The governing body shall:

(a) Insure that all health care personnel for whom state licenses or

registration are required are currently licensed or registered;

(b) Insure that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications;

(c) Insure that procedures for granting, restricting, and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and

(d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care.

441.705 Definitions for ORS 441.705 to 441.745. (1) "Person" means a licensee

under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.320, 442.340 to 442.350 and 442.400 to 442.450, or a person whom the assistant director finds should be so licensed but is not, but does not include any employee of such licensee or person.

(2) "Direct patient care or feeding" means any care provided directly to or for any patient related to that patient's physical, medical and dietary well-being as defined by rules of the Health Division.

(3) "Staff to patient ratio" means the number and training of persons providing direct patient care as defined in rules of the Health Division.

441.710 Civil penalties; when imposed.

(1) In addition to any other liability or penalty provided by law, the Assistant Director for Health may impose a civil

penalty on a person for any of the following:

(a) Violation of any of the terms or conditions of a license issued under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.320, 442.340 to 442.350 and 442.400 to 442.450 for a long term care facility, as defined in ORS 442.015.

(b) Violation of any rule or general order of the Health Division that pertains to a long term care facility.

(c) Violation of any final order of the assistant director that pertains specifically to the long term care facility owned or operated by the person incurring the penalty.

(d) Violation of ORS 441.605 or of rules required to be adopted under ORS 441.610.

(2) A civil penalty may not be imposed under this section for violations other than those involving direct patient care or feeding, an adequate staff to patient ratio, sanitation involving direct patient care or a violation of ORS 441.605 or of the rules required to be adopted by ORS 441.610 unless a violation is found on two consecutive surveys of the long term care facility. The assistant director in every case shall prescribe a reasonable time for elimination of a violation:

(a) Not to exceed 30 days after first notice of a violation; or

(b) In cases where the violation requires more than 30 days to correct, such time as is specified in a plan of correction found acceptable by the assistant director.

441.712 When civil penalty due; notice; hearing. (1) Any civil penalty

imposed under ORS 441.710 shall become due and payable when the person incurring the penalty receives a notice in writing from the Assistant Director for Health. The notice referred to in this section shall be sent by registered or certified mail and shall include:

(a) A reference to the particular sections of the statute, rule, standard or order involved;

(b) A short and plain statement of the matters asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the party's right to request a hearing.

(2) The person to whom the notice is addressed shall have 10 days from the date of mailing of the notice in which to make written application for a hearing before the assistant director.

(3) All hearings shall be conducted pursuant to the applicable provisions of ORS 183.310 to 183.550.

441.715 Schedule of civil penalties.

(1)(a) After public hearing, the Assistant Director for Health by rule shall adopt a schedule establishing the civil penalty that may be imposed under ORS 441.710. However, the civil penalty may not exceed \$500 for each violation.

(b) Notwithstanding the limitations on the civil penalty in paragraph (a) of this subsection, for any violation involving direct patient care or feeding, an adequate staff to patient ratio, sanitation involving direct patient care or a violation of ORS 441.605 or rules required to be adopted under ORS 441.610, a penalty may be imposed for each day the violation occurs in an amount not to exceed \$500 per day.

(2) The penalties assessed under subsection (1) of this section shall not exceed \$6,000 in the aggregate with respect to a single long term care facility within any 90-day period.

441.820 Procedure for termination of physician's privilege to practice medicine at health care facility; immunity from damage action for good faith report.

(1) When a health care facility restricts or terminates the privileges of a physician to practice medicine at that facility, it shall promptly report, in writing, to the Board of Medical Examiners for the State of Oregon all the facts and circumstances that resulted in the restriction or termination.

(2) A health care facility which reports or provides information to the Board of Medical Examiners for the State of Oregon under this section and which provides information in good faith shall

not be subject to an action for civil damages as a result thereof.

677.015 Statement of Purpose.

Recognizing that to practice medicine is not a natural right of any person but is a privilege granted by legislative authority, it is necessary in the interests of the health, safety and welfare of the people of this state to provide for the granting of that privilege and the regulation of its use, to the end that the public is protected from the practice of medicine by unauthorized or unqualified persons and from unprofessional conduct by persons licensed to practice under this chapter.
[1967 c.470 §2]

677.095 Duty of Care. A physician or podiatrist licensed to practice medicine or podiatry by the Board of Medical Examiners for the State of Oregon has the duty to use that degree of care, skill and diligence

which is used by ordinarily careful physicians or podiatrists in the same or similar circumstances in the community of the physician or podiatrist or a similar community.

677.190 Grounds for suspending, revoking or refusing to grant license, registration or certification. The board may refuse to grant, or may suspend or revoke a license to practice medicine or podiatry in this state, or may refuse to grant, or may suspend or revoke the registration or certification of any other person registered, certified or otherwise controlled by the board for any of the following reasons:

- (1) Unprofessional or dishonorable conduct.
- (2) Employing any person to solicit patients for the licensee.

(3) Representing to a patient that a manifestly incurable condition of sickness, disease or injury can be cured.

(4) Obtaining any fee by fraud or misrepresentation.

(5) Wilfully or negligently divulging a professional secret.

(6) Conviction of any offense punishable by incarceration in a state penitentiary or in a federal prison, subject to ORS 670.280. A copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence.

(7) Habitual or excessive use of intoxicants, drugs, or controlled substances.

(8) Fraud or misrepresentation in applying for or procuring a license to practice in this state, or in connection

with applying for or procuring registration.

(9) Making false or misleading statements regarding skill or efficacy or value of the medicine, treatment or remedy prescribed or administered by the licensee or at the direction of the licensee in the treatment of any disease or other condition of the human body or mind.

(10) Impersonating another person licensed to practice medicine or podiatry or permitting or allowing any person to use the license or certificate of registration.

(11) Aiding or abetting the practice of medicine or podiatry by a person not licensed by the board.

(12) Using the name of the licensee under the designation "doctor," "Dr.," "D.O.," or "M.D.," "D.P.M.," "Acupuncturist," E.M.T. II, III, or IV, "P.A.," or any other similar designation

with reference to the commercial exploitation of any goods, wares or merchandise.

(13) Insanity or mental disease as evidenced by an adjudication or by voluntary commitment to an institution for treatment for mental disease, as determined by an examination conducted by three impartial psychiatrists retained by the board.

(14) Gross negligence or repeated negligence in the practice of medicine or podiatry.

(15) Manifest incapacity to practice medicine or podiatry.

(16) The suspension or revocation by another state of a license to practice medicine or podiatry, based upon acts by the licensee similar to acts described in this section. A certified copy of the record of suspension or revocation of the

state making such suspension or revocation is conclusive evidence thereof.

(17) Failing to designate the degree appearing on the license under circumstances described in ORS 677.184(3).

(18) Wilfully violating any provision of this chapter or rule adopted by the board.

(19) Failing to report the change of the location of practice of the licensee as required by ORS 677.170.

(20) Adjudication of or admission to a hospital for mental illness or imprisonment as provided in ORS 677.225.

(21) Making a fraudulent claim.

(22) (a) Performing psychosurgery.

(b) For purposes of this subsection and ORS 426.385, "psychosurgery" means any operation designed to produce an irreversible lesion or destroy brain tissue for the primary purpose of altering the

thoughts, emotions or behavior of a human being. "Psychosurgery" does not include procedures which may produce an irreversible lesion or destroy brain tissues when undertaken to cure well-defined disease states such as brain tumor, epileptic foci and certain chronic pain syndromes.

(23) Refusing an invitation for an informal interview with the board requested under ORS 677.415.

(24) Violation of Federal Controlled Substance Act.

(25) Prescribing controlled substances without a legitimate medical purpose and without following accepted procedures for examination of patients and record keeping.

677.200 Disciplinary procedure.

Except as provided in ORS 677.202, any proceeding for suspension or revocation of a license to practice medicine in this

state shall be substantially in accord with the following procedure:

(1) A written complaint of some person, not excluding members or employee of the board, shall be verified and filed with the board.

(2) A hearing shall be given to the accused in accordance with ORS 183.310 to 183.550 as a contested case.

(3) The hearing may be before the board or may be before three or more members or a qualified hearing officer designated by the chairman of the board to take testimony and conduct the hearing. If the hearing is before one or more members of the board or a hearing officer designated by the chairman, a transcript of the testimony taken, together with any exhibits produced, shall be furnished to the board. The accused or the attorney of the accused, or both, may be present at the

meeting at which the transcript is considered by the board and may be given an opportunity to argue and sum up the accuse's position before the board.

677.202 When procedure inapplicable.

ORS 677.200(1) and (2) do not apply in cases wherein:

(1) The Board has refused to accept an application for licensing or has denied licensing to a person applying for a license to practice medicine or podiatry in this state.

(2) The license of a person to practice medicine or podiatry in this state has been suspended automatically as provided in ORS 677.160, 677.170, 677.225 or 677.850.

677.205 Grounds for discipline; action by board. (1) The Board may discipline as provided in this section any person licensed, registered or certified to

practice medicine or podiatry in this state who has:

(a) Admitted the facts of a complaint filed in accordance with ORS 677.200(1) alleging facts which establish that such person is guilty of violation of one or more of the grounds for suspension or revocation of a license as set forth in ORS 677.190;

(b) Been found guilty in accordance with ORS 677.200 of violation of one or more of the grounds for suspension or revocation of a license as set forth in ORS 677.190; or

(c) Had an automatic license suspension as provided in ORS 677.225.

(2) In disciplining a licensee as authorized by subsection (1) of this section, the board may use any or all of the following methods:

(a) Suspend judgment.

(b) Place licensee on probation.

(c) Suspend the license of the licensee to practice medicine or podiatry in this state.

(d) Revoke the license of the licensee to practice medicine or podiatry in this state.

(e) Place limitations on this license of the licensee to practice medicine or podiatry in this state.

(f) Take such other disciplinary action as the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings or assessment of a fine not to exceed \$5,000 or both.

(3) In addition to the action authorized by subsection (2) of this section, the board may temporarily suspend a license without a hearing, simultaneously with the commencement of proceedings under

ORS 677.200 if the board finds that evidence in its possession indicates that a continuation in practice of the licensee constitutes an immediate danger to the public.

(4) If the board places any licensee on probation as set forth in paragraph (b) of subsection (2) of this section, the board may determine, and may at any time modify, the conditions of the probation and may include among them any reasonable condition for the purpose of protection of the public and for the purpose of rehabilitation of the probationer, or both. Upon expiration of the term of probation, further proceedings shall be abated if the licensee has complied with the terms of the probation.

(5) If the license to practice medicine or podiatry in this state is suspended, the holder of the license may

not practice during the term of the suspension. Upon the expiration of the term of suspension, the license shall be reinstated by the board if the conditions for which the license was suspended no longer exist.

(6) The board shall enter each case of disciplinary action on its records.
[1957 c.681 §8; 1967 c.470 §34; 1975 c.796 §3; 1983 c.486 §25]

677.208 Hearing; judicial review.

(1) Where the board proposes to refuse to issue a license, or refuses to restore an inactive registrant to an active registration, or proposes to revoke or suspend a license, opportunity for hearing shall be accorded as provided in ORS 183.310 to 183.550.

(2) Judicial review of orders under subsection (1) of this section shall be in accordance with ORS 183.310 to 183.550.

(3) If the final order of the court on review reverses the board's order of suspension or revocation, the board shall issue the license and reinstate appellant not later than the 30th day after the decision of the court.

(Board of Medical Examiners)

677.235 Board of Medical Examiners; membership; terms; vacancies; confirmation.

(1) The Board of Medical Examiners for the State of Oregon consists of nine members appointed by the Governor. Six of the members shall be appointed from among persons having the degree of Doctor of Medicine, and two from among persons having the degree of Doctor of Osteopathy. In addition to the eight named persons described, there shall be appointed one public member representing health consumers. All persons appointed must have been residents of this state for at least

seven years. The physician members must have been in the active practice of their profession for at least five years immediately preceding their appointment. Neither the public member nor any person within the immediate family of the public member shall be employed as a health professional or in any health-related industry. The public member shall participate at all times the board or any committee or part thereof sits in an investigative capacity.

(2) Not later than February 1 of each year, the Oregon Medical Association shall nominate three qualified physicians for each physician member of the board whose term expires in that year, and shall certify its nominees to the Governor. Not later than the 30th day before the expiration of the term of each osteopathic member of the board, the Osteopathic

Physicians and Surgeons of Oregon, Inc. shall nominate three physicians possessing the degree of Doctor of Osteopathy and shall certify its nominees to the Governor. The Governor shall consider these nominees in selecting successors to retiring board members.

(3) Each member of the board shall serve for a term of four years beginning on March 1 of the year the member is appointed and ending February 28 of the fourth year thereafter. If a vacancy occurs on the board, another member possessing the same professional degree or fulfilling the same public capacity as the person whose position has been vacated shall be appointed as provided in this section to fill the unexpired term.

(4) All appointments of members of the board by the Governor are subject to

confirmation by the Senate in the manner provided in ORS 171.562 and 171.565.

677.275 Executive secretaries; hearing officers. The board may appoint:

(1) One or more executive secretaries, who need not be members of the board, and fix their compensation. Each executive secretary shall be under the supervision and control of the board, and may discharge the duties of the secretary-treasurer as provided in the rules of the board.

(2) One or more hearing officers, who need not be members of the board, and fix their compensation. Each hearing officer is vested with the full authority of the board to schedule and conduct hearings on behalf and in the name of the board on all matters referred by the board, including proceedings for placing licensees on probation and for suspension and revocation

of licenses, and shall cause to be prepared and furnished to the board, for decision thereon by the board, the complete written transcript of the record of the hearing. This transcript shall contain all evidence introduced at the hearing and all pleas, motions and objections, and all rulings of the hearing officer. Each hearing officer may administer oaths and issue summonses, notices and subpoenas, but may not place any licensee on probation or issue, refuse, suspend or revoke a license.

677.280 Employment of personnel; compensation and expenses of board members.

(1) Subject to any applicable provisions of the State Personnel Relations Law, the board may employ inspectors, special agents and investigators for the purpose of enforcing the laws relating to the practice of medicine and securing evidence of violations thereof, and necessary clerical

assistants, and may fix the compensation therefor and incur necessary other expenses.

(2) The board members are entitled to compensation and expenses as provided in ORS 292.495. [Amended by 1967 c.470 §54; 2969 c.314 §78]

(Enforcement)

677.320 Investigation of complaints and suspected violations. (1) Upon the complaint of any citizen of this state, or upon its own initiative, the board may investigate any alleged violation of O.R.S. chapter 677. If, after the investigation, the board has reason to believe that any person is subject to prosecution criminally for the violation of this chapter, it shall lay the facts before the proper district attorney.

(2) In the conduct of investigations, the board may:

(a) Take evidence;

(b) Take the depositions of witnesses, including the person charged, in the manner provided by law in civil cases;

(c) Compel the appearance of witnesses, including the person charged, before it in person the same as in civil cases;

(d) Require answers to interrogatories; and

(e) Compel the production of books, papers, accounts, documents and testimony pertaining to the matter under investigation or the hearing.

(3) In exercising its authority under subsection (2) of this section, the board may issue subpoenas over the signature of the executive secretary and the seal of the board in the name of the State of Oregon.

677.325 Enjoining unlicensed practice of medicine. The board may maintain a suit

for an injunction against any person violating ORS 677.080(4). Any person who has been so enjoined may be punished for contempt by the court issuing the injunction. An injunction may be issued without proof of actual damage sustained by any person. An injunction shall not relieve a person from criminal prosecution for violation of ORS 677.080(4).

677.330 Duty of district attorney and Attorney General; jurisdiction of prosecutions. (1) The district attorney of each county shall prosecute any violation of this chapter occurring in the county. The board shall be represented by the Attorney General acting under ORS 180.140. Each district attorney shall bring to the attention of the grand jury of the county any acts complained of by the board as a violation of the provisions of this chapter.

(2) Upon any appeal to the Court of Appeals of this state in any of the proceedings referred to in subsection (1) of this section, the Attorney General shall assist the district attorney in the trial of the cause in the Court of Appeals.

(3) Justices' courts, district courts and the circuit courts have concurrent jurisdiction of prosecutions for the violation of this chapter.

677.335 Official actions of board and personnel; privileges and immunities; scope of immunity of complainant. (1) Members of the board, members of its administrative and investigative staff, its attorneys acting as prosecutors or counsel shall have the same privilege and immunities from civil and criminal proceedings arising by reason of official actions as prosecuting and judicial officers of the state.

(2) No person who has made a complaint as to the conduct of a licensee of the board or who has given information or testimony relative to a proposed or pending proceeding for misconduct against the licensee of the board, shall be answerable for any such act in any proceeding except for perjury committed by the person.

677.415 Investigation of incompetence; reports to board; informal interview.

(1) The board on its own motion may investigate any evidence which appears to show that a licensee licensed by the board is or may be medically incompetent or is or may be guilty of unprofessional or dishonorable conduct or is or may be mentally or physically unable safely to engage in the practice of medicine or podiatry.

(2) Any health care facility licensed under ORS 441.015 to 441.087 and 441.820, any licensee licensed by the board, the Oregon Medical Association, Inc., or any component society thereof, the Osteopathic Physicians and Surgeons of Oregon, Inc. or the Oregon Podiatric Medical Association shall, and any other person may, report to the board any information such licensee, association, society or person may have which appears to show that a licensee is or may be medically incompetent or is or may be guilty of unprofessional or dishonorable conduct or is or may be mentally or physically unable safely to engage in the practice of medicine or podiatry.

(3) If in the opinion of the board it appears such information provided to it under provisions of this section is or may be true, the board may request an informal interview with the licensee.

677.420 Competency examination; investigation; consent by licensee; assistance. (1) Notwithstanding any other provisions of this chapter, the board may at any time direct and order a mental, physical or medical competency examination or any combination thereof, and make such investigation, including the taking of depositions or otherwise in order to fully inform itself with respect to the performance or conduct of a licensee.

(2) If the board has reasonable cause to believe that any licensee is or may be unable to practice medicine or podiatry with reasonable skill and safety to patients, the board shall cause a competency examination of such licensee for purposes of determining the fitness of the licensee to practice medicine or podiatry with reasonable skill and safety to patients.

(3) Any licensee by practicing or by filing a registration to practice medicine or podiatry shall be deemed to have given consent to submit to mental or physical examination when so directed by the board and, further, to have waived all objection to the admissibility of information derived from such mental or physical or medical competency examination on the grounds of privileged communication.

(4) The board may request the Oregon Medical Association, Inc., Oregon Osteopathic Association or the Oregon Podiatry Association or any of them to assist the board in preparing for or conducting any medical competency examination as the board may deem appropriate.

677.425 Confidential information; immunity. (1) Any information provided to the board pursuant to ORS 677.200, 677.205,

677.410 to 677.425 or 677.860 is confidential and shall not be subject to public disclosure, nor shall it be admissible as evidence in any judicial proceeding.

(2) Any person who reports or provides information to the board under ORS 677.205, 677.410 to 677.425 and 677.860 and who provides information in good faith shall not be subject to an action for civil damages as a result thereof.

677.435 Reports of alleged professional negligence; duties of Insurance Commissioner. (1) Any insurer or approved self-insurance association required to report claims of alleged professional negligence to the board under ORS 743.770 shall advise the board of any settlements, awards or judgments against a physician or podiatrist upon receipt of a written request from the board.

(2) The board shall provide the Insurance Commissioner copies of the reports required under ORS 743.770 and subsection (1) of this section.

(3) The Insurance Commissioner shall maintain a permanent record of the reports filed with the Insurance Commissioner under ORS 743.770 and subsection (1) of this section and provide an index of such reports. The Insurance Commissioner, at least once every month, shall send those reports to each health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.810 to 441.820, 441.990, 442.320, 442.340 to 442.350 and 442.400 to 442.450 and to the board.

REPLY BRIEF

4
No. 86-1145

Supreme Court, U.S.
FILED

FEB 26 1987

JOSEPH F. SPANIOL, JR.
CLERK

IN THE
Supreme Court of the United States

OCTOBER TERM, 1986

TIMOTHY A. PATRICK, M.D.,
Petitioner,
v.

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTLEKAMP, M.D.,
PATRICK MEYER, M.D.,
GARY M. BOELLING, M.D.,
ROBERT D. NEIKES, M.D.,
FRANKLIN D. RUSSELL, M.D.,
LEIGH C. DOLIN, M.D.,
RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,
Respondents.

On Petition for Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

REPLY BRIEF FOR THE PETITIONER

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1986

No. 86-1143

TIMOTHY A. PATRICK, M.D.,
v. *Petitioner,*

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTLEKAMP, M.D.,
PATRICK MEYER, M.D.,
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RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,
Respondents.

On Petition for Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

REPLY BRIEF FOR THE PETITIONER

I. THE FACTS OF THIS CASE ARE NOT IN DISPUTE.

Defendants' brief in opposition recites a statement of facts which bears little resemblance to the facts stated in the opinion of the Court of Appeals. Their counsel no doubt has heard that this Court is disinclined to accept "fact-bound" petitions, and wishes to make it appear that this is one. However, counsel should not be allowed to violate fundamental rules of appellate procedure in order to deceive this Court into so thinking.

The version of the facts which defendants recite is to the effect that they acted in appropriate good faith to rid the hospital of a dangerous surgeon. This is the version which they argued to the jury, but which the jury unanimously rejected. When the jury disbelieved this evidence, counsel's duty on appeal then became to present the facts in the light most favorable to plaintiff: that defendants had acted in bad faith, for an anticompetitive motive, to rid themselves of an effective competitor in a way which the Court of Appeals itself later described as "shabby, unprincipled, and unprofessional". Appendix 17a.

Defendants' version of the facts is irrelevant now. The Court of Appeals, as well as the jury, accepted plaintiff's version. Whatever the underlying facts, what matters now is that the law in the Ninth Circuit—and apparently also in the Fourth and Seventh Circuits—that physicians have absolute immunity under the antitrust laws to abuse the peer review process, in bad faith for anticompetitive purposes, in order to exclude a more effective and competent competing physician.

II. THE RECENT STATUTE MAKES CERTIORARI IN THIS CASE MORE IMPORTANT, NOT LESS.

The American Hospital Association and four other organizations seek to appear amicus curiae in order to oppose the petition for certiorari. They argue that this case is no longer worthy of much attention after the enactment of the recent federal statute dealing with peer review. They say that any decision in this case will have little or no precedential value in light of the recent statute.

These would-be amicus curiae have not gone to the trouble of appearing here simply to keep this Court from wasting its time on an unimportant case. They have more at stake than a friendly interest in this Court's docket, more at stake even than protecting these par-

ticular defendants from the consequences of their wrongdoing. It is precisely because this is an important case, and an important precedent, that they wish this Court not to disturb it.

The decision below grants absolute immunity even in cases of wrong-doing, and it is that absolute immunity which these would-be amicus curiae want for the physicians who are in control of the medical staff of their hospitals. They argue that antitrust is dangerous to peer review, that physicians who participate should do so without fear of any liability. This is a policy argument, however, and it has failed everywhere except in the courts. Congress refused to grant absolute immunity, and instead granted only a good-faith immunity. Neither have the states granted absolute immunity: Oregon and thirty other states grant only good faith immunity. The only source of absolute immunity is the opinions of the Courts of Appeal below, principally the Ninth Circuit in this case. Hence, the effort of these would-be amicus curiae to preserve that opinion, even by arguing disingenuously that it is no longer important after the recent federal statute.

The legislative history makes it clear that this case retains its importance. As Rep. Waxman noted, the effect of the statute depends on the outcome of this case. He said that the limited good faith immunity allowed by the statute will be irrelevant, at least in many states, if the absolute immunity provided in the decision below is allowed to stand. If this Court does not decide the question now, confusion must therefore follow in the forthcoming disputes over absolute versus good faith immunity. Yet our adversaries tell this Court that "a grant of certiorari would create confusion and uncertainty." Respondents' Brief 22. It is a curious argument that this Court makes things worse by taking cases.

III. THE RECENT STATUTE IS RELEVANT IN DETERMINING THE INTENT OF CONGRESS AS IT APPLIES TO THIS CASE.

This recent statute shows that what defendants did is not within the immunity intended by Congress, not now. Although the view of this later Congress does not establish definitely the meaning of the earlier statute, it can have persuasive value. *Bell v. New Jersey and Pennsylvania*, 461 U.S. 773 (1983).

IV. THE UNFORTUNATE EFFECT OF THE DECISION BELOW EXTENDS BEYOND PHYSICIANS AND PEER REVIEW: IT EXTENDS THE STATE ACTION DOCTRINE TOO FAR.

Respondents suggest this is a matter of the interpretation of Oregon law which should not interest this Court. However, the whole point of the state action doctrine is to investigate relevant state law to determine its intersection with federal antitrust law. Moreover, the Oregon statutes are similar to those in most of the states.

Respondents list a number of Oregon statutes—most of them irrelevant and frequently misrepresented—in support of their view. There is one Oregon statute which they never even mentioned, however, and did not even cite in their table of authorities: the Oregon statute which provides that participants in peer review only have immunity provided they act in good faith. Or. Rev. Stat. § 41.675(4). In this statute is the clearest expression of intent of the Oregon Legislative that defendants' actions in bad faith are contrary to state policy and are outside the protection of state law. The State of Oregon disowns their acts, yet the Ninth Circuit insists that the State of Oregon intended to shelter them. Contrary to what respondents say, this Court has never held that corrupt actions of this sort are protected by the state action doctrine, especially when the state itself refuses to protect them.

What the Ninth Circuit has done is to incorporate into the state action doctrine a notion of preemption: if the state has acted in a certain area, it has in effect preempted that area from the antitrust laws. This version of the state action doctrine ignores the true source of the state action doctrine and in so doing ignores the intent of the Legislature.

This expansive version of the state action doctrine is not necessarily limited to hospitals and peer review. It can apply to any line of commerce, regardless of the recent statute dealing with peer review.

V. RESPONDENTS MISLEAD THE COURT ABOUT THE EXISTENCE OF ACTIVE SUPERVISION BY THE STATE.

Respondents would make it appear that there is active supervision by the state when in fact there is none. For example, it is false to imply that the Board of Medical Examiners has review power over peer review decisions (Respondents' Brief 32) when the statutes give it none. Neither does the general supervisory powers of the Health Division over hospitals amount to active supervision of the peer review process. If the state action doctrine exempts from the antitrust laws any anticompetitive behavior by any competitor in an industry which has some general state supervision, it will have swallowed up the antitrust laws.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

JUL 14 1987

JOSEPH F. SPANIOLO, JR.
CLERK

No. 86-1145

In the Supreme Court of the United States

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, PETITIONER

v.

WILLIAM M. BURGET, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE

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21/97

QUESTIONS PRESENTED

1. Whether the "state action doctrine" bars a doctor's antitrust action against competing doctors who allegedly used a hospital peer review process in bad faith to restrain competition, when (1) the State mandates medical staff peer review in order to identify doctors whose performance is substandard and (2) (a) hospitals are required to examine peer review procedures, (b) hospitals are required to report termination or restriction of hospital privileges to the state Board of Medical Examiners, and (c) limited judicial review of adverse privilege decisions may (or may not) be available.

2. Whether the conduct of private physicians in connection with proceedings of the state Board of Medical Examiners is properly admissible as evidence of those physicians' intent in invoking the peer review process at a private hospital or is actionable as part of a conspiracy in restraint of trade involving such peer review proceedings.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1145

TIMOTHY A. PATRICK, PETITIONER

v.

WILLIAM M. BURGET, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. Petitioner is a surgeon practicing in Astoria, Oregon, a city of 10,000 people. Respondents are physicians who are partners in the Astoria Clinic. During the relevant time periods, a majority of the staff members at Columbia Memorial Hospital (CMH), Astoria's only hospital, were employees or partners of the Astoria Clinic. Petitioner, who after his initial year as an employee had declined an invitation to join the Astoria Clinic as a partner, had an independent practice in competition with some of the doctors at the Clinic. Pet. App. 2a-3a.

In late 1979, respondent Boelling, a Clinic physician, complained to the hospital medical staff about an incident in which Boelling said that one of petitioner's patients was

left in the care of another physician, who then left the patient unattended (Pet. App. 4a-5a). This complaint, along with other cases allegedly handled by petitioner, was referred to the state Board of Medical Examiners (BOME), whose three-member investigative committee was chaired by respondent Russell, another Clinic physician (*id.* at 5a). The BOME issued a letter of reprimand, but that letter was retracted when petitioner sought judicial review (*id.* at 5a-6a).

In 1981, at the initiation of respondent Harris, another Clinic physician, the peer review committee at CMH began proceedings to terminate petitioner's hospital privileges (Pet. App. 7a). Respondent Boelling served as chairman of the committee. He had earlier complained about petitioner to the BOME and had in that forum testified against petitioner concerning some of the cases that were now before the committee. Eventually, petitioner resigned from the hospital staff rather than risk termination. *Id.* at 7a-8a.¹

2. Petitioner filed suit against the Astoria Clinic and its physicians, alleging violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. 1 and 2, and bringing related state claims (Pet. App. 8a). Petitioner contended that respondents' primary motive, in conducting the peer review process, was to reduce or eliminate competition from petitioner rather than to improve patient care; respondents vigorously denied this. The jury was instructed as to the Section 2 claim that it should find for respondents if it determined that they were "motivated by concerns over provision of health care to the community" (Tr. 2922). The jury, however, returned a verdict against Russell,

¹ The court of appeals did not address the issues raised by petitioner's decision to resign before termination of his privileges (Pet. App. 14a n.7), and respondents have not pursued the point in this Court.

Boelling, and Harris on petitioner's Section 1 claim and against the Clinic on the Section 2 claim. The jury awarded petitioner damages of \$650,000, which the district court trebled, on his antitrust claims plus \$20,000 compensatory and \$90,000 punitive damages on the state law claims. Pet. App. 8a.

3. The court of appeals reversed.² It applied the two-prong test articulated in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980), and applied to private conduct in *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 57 (1985). Under that test, the "state action doctrine" immunizes private conduct from challenge under the antitrust laws if (1) the private conduct is undertaken pursuant to a clearly articulated state policy to displace competition, and (2) there is active supervision of the private conduct by the state. The court held that both parts of this test were satisfied here and therefore ruled that, even if respondents had misused the hospital peer review process to disadvantage a competitor rather than to improve patient care, the state action doctrine shielded their conduct from antitrust scrutiny (Pet. App. 9a, 12a-13a, 17a).

The court of appeals concluded that the State had clearly articulated a policy to limit competition because "Oregon, by compelling physicians to review their competitors, affirmatively has expressed a policy to replace pure competition with some regulation" (Pet. App. 10a). It noted that Oregon law requires hospitals to "insure that procedures exist for granting or restricting privileges of the medical staff and that the medical staff is organized in such a manner as effectively to review one another's professional practices at the facility to reduce morbidity and mortality and to improve patient care" (Pet. App. 9a-10a (citing Or.

² The court, however, viewing the evidence in the light most favorable to petitioner, characterized respondents' conduct as "shabby, unprincipled and unprofessional" (Pet. App. 17a).

Rev. Stat. §§ 441.030, 441.055(3)(c) and (d) (1985))). Therefore, the court said, Oregon has shown an intent to limit consumer choice as to physicians. Pet. App. 11a-12a.

The court of appeals also concluded that Oregon actively supervises the private parties who carry out peer review, thereby satisfying the second prong of the *Midcal* test. Active supervision is demonstrated, it held, by "the combination of" a requirement that hospitals promptly report privilege terminations to the BOME, a requirement that health care facilities regularly review their privilege termination procedures, and the possibility of judicial review of adverse privilege decisions in the Oregon state courts. Pet. App. 10a-11a.

The court of appeals determined that Russell's activities as a member of the BOME also were exempt from anti-trust liability under the state action doctrine. In its view, Russell's activities were actions within the scope of a state official's authority, taken pursuant to express state policy, and were contemplated by the State. Pet. App. 12a.

Finally, acknowledging that there was substantial evidence that respondents had acted in bad faith, the court found unpersuasive petitioner's contention that the state had articulated a policy only in favor of good-faith peer review (Pet. App. 12a-13a). Noting that a state rarely, if ever, authorizes bad-faith actions "as such," the court of appeals refused to inquire into the motives of peer reviewers in determining whether the state action exemption applied (*id.* at 13a-14a).³

³ Although the court acknowledged that Oregon law grants immunity under state law only for good-faith peer review activity, it held that this fact demonstrated that petitioner had a state law remedy for any bad-faith actions (Pet. App. 13a-14a).

DISCUSSION

1. The first question presented — whether the state action doctrine immunizes respondents' actions in connection with the hospital peer review process — merits review by this Court.⁴ The court of appeals' interpretation of the "active supervision" prong of the *Midcal* test misapplies this Court's precedents and would exempt from the anti-trust laws a wide variety of private conduct that cannot, on the basis of the sort of showing that was made here, be attributed to the state.⁵ Since there are few decisions of

⁴ We do not think the Court should grant certiorari as to the second question presented by the petition. Petitioner would be free to litigate in the courts below the only BOME-related question that is actually addressed in the body of his petition (at 19): whether, at any remaining trial, evidentiary use may be made of Russell's alleged abuse of his BOME position. The court of appeals did not pass on that evidentiary question (although, contrary to respondents' assertion (Br. in Opp. 37-38), petitioner did *argue* to the court of appeals that the BOME proceedings were admissible as evidence relating to the broader conspiracy (see Appellees' C.A. Br. 82)). There is no need for this Court to address that evidentiary question in the first instance.

⁵ There is no split in the circuits, but the disagreement between the court below and the Seventh Circuit, on the one hand, and some of the district courts, on the other, illustrates the lack of clarity in this area. Compare *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984) (consistent with decision below), cert. denied, 472 U.S. 1027 (1985), and *Doe v. St. Joseph's Hosp.*, 788 F.2d 411 (7th Cir. 1986) (following *Marrese*), with *Quinn v. Kent General Hosp. Inc.*, 617 F. Supp. 1226, 1238-1239 (D. Del. 1985) (rejecting *Marrese*), and *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1118 (E.D. Pa. 1986) (same). Commentators likewise have criticized the approach taken by the court below and the Seventh Circuit. See, e.g., Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case W. Res. L. Rev. 1117, 1163 & n.136 (1986) (describing both *Marrese* and the decision below as "unconvincing"). The difficulty of the area is highlighted by the fact that, when review of *Marrese* was sought in this Court (No. 84-1406), six States and the District of Columbia filed an amicus brief supporting a grant of certiorari and arguing that the decision of the Seventh Circuit was wrong. Among those States was Indiana — the very State

this Court discussing "active supervision," the weakening of this portion of the *Midcal* test is of considerable importance in a variety of contexts. In addition, guidance from this Court on that subject would be of particular use to the parties and courts in hospital peer review cases.

The issue in this case is not, as amici contend (Br. in Opp. of Joint Comm'n on Accreditation of Hospitals et al. 4-5), rendered unimportant to hospital peer review cases by the passage of the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, Tit. IV, 100 Stat. 3784-3794 (1986 Act). Medical peer review is an important process,⁶ and the 1986 Act protects that process from antitrust damage liability in cases covered by the statute. But the 1986 Act in no way displaces the "state action" doctrine.⁷ On the one hand, the 1986 Act is not the exclusive source of immunity for peer review activities: to the con-

that had been held in *Marrese* to have shielded peer review from antitrust scrutiny under the state action doctrine. By contrast, the State of Oregon appeared as amicus in the court of appeals in this case, urging the court to find state action immunity.

⁶ In adopting the 1986 Act, Congress found that "effective professional peer review" is an important tool for the maintenance of high standards of medical care (§ 402, 100 Stat. 3784). Peer review can have significant procompetitive effects. Procedures designed to raise competence standards can help to simulate the results that would obtain if consumers had the knowledge to make fully informed judgments about the medical services they select. Moreover, the enforcement of competence standards through the denial of staff privileges may enhance a hospital's ability to compete with other hospitals and may yield important efficiencies. See Havighurst, *Doctors & Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1128-1131. (1984).

⁷ The 1986 Act, which is not retroactive (see § 416, 100 Stat. 3788), is not applicable to this case in any event. Accordingly, petitioner's proposed alternative disposition (Pet. 11 n.8) of vacating the decision below and remanding for reconsideration in light of the 1986 Act is not appropriate.

trary, it expressly provides that it does not change other "immunities under law" (§ 415(a), 100 Stat. 3787). On the other hand, the 1986 Act was not specifically designed to protect state prerogatives and does not itself bar the federal antitrust court from scrutinizing the defendant's conduct or from imposing liability if the plaintiff establishes by a preponderance of the evidence that the peer review action does not meet the federal standards specified in the 1986 Act, including the requirement that the action has been taken "in the reasonable belief that the action was in the furtherance of quality health care" (§ 412(a), 100 Stat. 3785-3786). In sum, in cases where peer review is undertaken pursuant to a state program, the question whether the private conduct constituted "state action" will — and should — remain the appropriate threshold inquiry, and the state action doctrine will remain pertinent to a large number of hospital peer review cases. In addition, of course, the 1986 Act does not in any way limit the impact of the decision below on peer review cases outside the health care area.

2. On the merits, we believe that the decision of the court of appeals is incorrect. The state action doctrine "represents an attempt to resolve conflicts that may arise between principles of federalism and the goal of the antitrust laws, unfettered competition in the marketplace" (*Southern Motor Carriers*, 471 U.S. at 62). Accordingly, the two-prong *Midcal* test is designed to ensure that a challenged restraint of trade is immune from antitrust scrutiny only if it is the product of state regulation and not merely the product of private anticompetitive interests. A restraint of the former type is immune because of "the assumption that Congress, in enacting the Sherman Act, did not intend to compromise the States' ability to regulate their domestic commerce" (*Southern Motor Carriers*, 471 U.S. at 56). A restraint of the latter type is not immune because a state may not give immunity to private parties

merely by "authorizing them to violate [the Sherman Act], or by declaring that their action is lawful." *Parker v. Brown*, 317 U.S. 341, 351 (1943).

Respondents failed to demonstrate the "active supervision" by the State of Oregon that would make their actions fairly attributable to the State.⁸ Thus, the court of appeals erred in finding the alleged anticompetitive actions in this case to be the product of state regulation, since the second prong of the *Midcal* test was not satisfied, and the judgment of the court of appeals is incorrect whether or not the first prong was satisfied. Whether the first prong is satisfied—*i.e.*, whether the State "clearly intend[ed] to displace competition in [this] field with a regulatory structure" (*Southern Motor Carriers*, 471 U.S. at 64)—is a more difficult question that need not be resolved in order for this Court to reverse.

a. This case involves an attempt by private parties, not governmental units, to achieve immunity from Sherman Act liability. As this Court has observed, "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 47 (1985); *cf. id.* at 45. It is for that reason that an "active state supervision" requirement is imposed, as "one way of ensuring that the actor is engaging in the challenged conduct pursuant to state policy" (*id.* at 46). Immunity from the federal antitrust laws under the state action doctrine is warranted only if the state provides, by one means or another, sufficient supervision to offer realistic assurance that, in the judgment of the state, private parties' exercise of discretion in particular instances furthers a state regulatory policy.

⁸ Respondents must demonstrate their entitlement to the state action defense. *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 400 (1978).

An essential element of this second prong of the *Midcal* test is that the state exercise ultimate control over the anti-competitive restraint. As is pointed out in *Midcal*, 445 U.S. at 104, this Court in the seminal state action case, *Parker v. Brown*, *supra*, stressed that the marketing plan proposed by California raisin growers did not take effect unless and until it was approved by a state board. Similarly, in *Southern Motor Carriers*, 471 U.S. at 51, the Court noted that the state public service commissions "have and exercise ultimate authority and control over all intrastate rates." Most recently, in *324 Liquor Corp. v. Duffy*, No. 84-2022 (Jan. 13, 1987), slip op. 9 n.7, the Court held that certain forms of state "monitoring" did not constitute active supervision because they did not "exert[] any significant control over retail liquor prices or mark-ups." See also 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 213b, at 73 (1978) ("The key question here is whether the operative decisions about the challenged conduct are made by public authorities or by private parties themselves. When the latter is the case, there is insufficient public control to confer antitrust immunity.").

Respondents have not demonstrated that Oregon has retained "ultimate authority and control" (see *Southern Motor Carriers*, 471 U.S. at 51) over medical staff peer review decisions or privilege decisions by hospitals. The court of appeals held that "the combination of [1] internal review by the hospitals, [2] review by the BOME, and [3] review by the courts constitutes adequate supervision" (Pet. App. 11a). Neither the court nor respondents have demonstrated, however, that as part of those three procedures any state official reviewed—or even could have reviewed—the results of this or any other private decision regarding hospital privileges to determine whether state policy had been followed and to correct any abuses.

(1) The statutory requirement that, as a condition of maintaining their licenses, hospitals regularly review their

peer review procedures for conformity with applicable law (see Or. Rev. Stat. §§ 441.030, 441.055(3)(c) (1985); Br. in Opp. App. 14-17) is entirely irrelevant to active supervision by the State. The hospital is a private actor, not a representative of the State.

Somewhat more relevant, although not discussed by the court of appeals, are the state Health Division's general supervisory and investigatory powers over all health matters, including the licensing of hospitals and the enforcement of health policies (see Or. Rev. Stat. §§ 431.110(1), 431.120(1), 431.140(1), 431.150, 441.015, 441.025, 441.055 (1985); Br. in Opp. App. 3-7, 12-17). The Health Division has the power to investigate and institute enforcement proceedings to restrain violations of public health laws, which presumably would include the statutory requirement that hospitals establish peer review procedures and review them regularly for compliance with state law (Or. Rev. Stat. §§ 431.150, 431.155 (1985); Br. in Opp. App. 6-9). The Health Division may also deny, suspend, or revoke a health care facility's license for failure to comply with that requirement (Or. Rev. Stat. § 441.030(2) (1985); Br. in Opp. App. 14).

Even if the Health Division has oversight responsibility with respect to the promulgation of peer review procedures by hospitals, that is not the same as the power to supervise the peer review process: there is no evidence that the Health Division has any power to overturn any peer review decision, no matter how far it departs from the State's policy.⁹ In general (and in this case), it is the private

⁹ Respondents assert (Br. in Opp. 34 n.8) that a physician who feels aggrieved by the peer review process may file a complaint for administrative relief. The Attorney General of Oregon made a similar assertion in the court of appeals (see C.A. Br. of Amicus Curiae State of Oregon 31-32). Respondents and the Attorney General, however, have cited no specific authority for that assertion, and the court of appeals did not rely on the possibility of such administrative proceedings. The Oregon statute mandating peer review (Or. Rev. Stat.

parties' actual decisions to exclude a doctor, and not the procedures by which those decisions are made, that are alleged to violate the antitrust laws. See, e.g., *Midcal*, 445 U.S. at 105-106 (emphasizing that California did not establish prices or review the reasonableness of particular price schedules as a reason for determining that it did not actively supervise the system of price maintenance required by statute).

(2) As the court of appeals noted, Oregon hospitals are required by statute to notify the BOME promptly of a decision to terminate privileges (see Or. Rev. Stat. § 441.820 (1985); Br. in Opp. App. 23-24). There is no indication, however, that the BOME has any authority to determine whether the termination of privileges was proper or to remedy any abuse. All that the statute suggests on its face is that the BOME will determine whether additional action on its part, such as revocation of a physician's license to practice medicine (see Or. Rev. Stat. § 677.190 (1985)), is warranted. There is no indication that the BOME has statutory authority to overturn hospital termination decisions. Nor have respondents shown that the BOME in practice undertakes any review or that it has

§ 441.055(3) (1985)) makes no specific mention of proceedings to review the result in a particular case. Nor is there specific provision in the statute for administrative orders requiring restoration of hospital privileges to a particular physician or requiring compensation of an injured physician. Rather, the Health Division's enumerated relief powers are limited to proceedings to remedy violations of the statute, which does not specifically prohibit termination of privileges for reasons unrelated to the standard of patient care. Indeed, the statute does not even make provision for a complaining physician to be accorded the status of a party in any investigative proceeding initiated by the Health Division. In the absence of a more specific showing by respondents that the Health Division offers an administrative remedy to physicians who believe that their hospital privileges have been wrongfully terminated, there is no basis for a conclusion that such review could constitute active state supervision.

ever asserted the authority to reverse the action of a hospital in a termination proceeding. Cf. *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 544-545 (5th Cir. 1978), (similar reporting provision in Florida's peer review statute would allow, but not require, the state medical board to take independent disciplinary action against a physician disciplined by peer review), cert. denied, 444 U.S. 924 (1979).

(3) Finally, respondents have not established that Oregon actively supervises privilege termination proceedings through judicial review. As an initial matter, it is not even clear that Oregon law affords any judicial review at all for physicians whose privileges have been terminated by a private hospital. There is no statutory provision for judicial review, and we are aware of no case in which an Oregon court has held that there is judicial review. The cases that respondents (and the court of appeals) cite do not so hold. *Straube v. Emmanuel Lutheran Charity Bd.*, 287 Or. 375, 383, 600 P.2d 381, 386 (1979) ("We have assumed (but not decided) for the purpose of this case that plaintiff is entitled to 'fair procedure' as a common law right."), cert. denied, 445 U.S. 966 (1980); *Huffaker v. Bailey*, 273 Or. 273, 275, 540 P.2d 1398, 1399 (1975) ("In view of our conclusion that petitioner cannot prevail even assuming the case is properly before us, we find it unnecessary to decide these interesting questions [of reviewability]. Therefore, we assume, but do not decide, that the hospital's decisions are subject to review by mandamus * * *").

Even assuming that state law provides some sort of remedy in the state courts, however, respondents have made no showing that the kind of judicial review that would be undertaken would constitute active supervision by the State.¹⁰ Respondents have not demonstrated, or

¹⁰ The reliance by the court of appeals (Pet. App. 11a) on *Hoover v. Ronwin*, 466 U.S. 558, 572 n.22 (1984), for the proposition that

even seriously suggested, that petitioner would be entitled to an evidentiary hearing in a state court on his claim that he was denied a fair hearing. Nor have they shown that the state court would review the merits of the termination of privileges to determine whether it accorded with substantive state policy—in this case, for example, whether the termination served the State's policy of maintaining high standards of patient care rather than respondents' private interests.

The available evidence suggests that, if Oregon courts were to review termination decisions at all, the review would be deferential and nonsubstantive. The *Straube* court indicated that a court "should [not] decide the merits of plaintiff's dismissal" and that "[i]t would be unwise for a court to do more than to make sure that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care" (287 Or. at 384, 600 P.2d at 386). The *Huffaker* court advocated "judicial restraint" and declared that it would not invalidate a decision "made in good faith and supported by an adequate factual basis" (273 Or. at 280-281, 540 P.2d at 1401). Such deferential review would not result in a determination that substantive state policy was being followed and hence would not make the actions of private parties actions of the State. In the absence of any indication that an Oregon court would judge respondents' conduct against the State's substantive standards, there is no reason to treat

the availability of judicial review in state courts demonstrates active supervision is misplaced. In *Ronwin* the state supreme court was "acting legislatively rather than judicially" (466 U.S. at 568), exercising the authority of the sovereign under the state constitution. This Court therefore decided that it "need not address the issues of 'clear articulation' and 'active supervision'" (*id.* at 569).

respondents' conduct as the State's rather than their own. See *Town of Hallie*, 471 U.S. at 46-47.¹¹

In sum, when a state actively supervises private parties' exercise of discretion under peer review procedures, and also meets the "clear articulation" test, the state action doctrine makes it unnecessary to superimpose on the state's active supervision the kind of fact-specific inquiry that federal courts are required by the 1986 Act to undertake in order to ensure that immunized conduct serves the policy of maintaining high standards of care.¹² If the decision of the court of appeals were left undisturbed, however, private conduct could be immunized from antitrust scrutiny, without regard to the 1986 Act, even though no state official had exerted any control over the conduct in question. Such a result would "frustrat[e] the national policy in favor of competition" (*Southern Motor Carriers*, 471 U.S. at 57) without serving the articulated policy of the state.

¹¹ We do not suggest that judicial review may never play a role in the state's supervision of private conduct, for purposes of the state action doctrine. As this Court has noted, establishment of a system of "regulatory oversight" demonstrates a state's commitment to a program of regulation. See *Southern Motor Carriers*, 471 U.S. at 61-62 n.23 (quoting 1 P. Areeda & D. Turner, *Antitrust Law* § 213a, at 73 (1978)). It is clear, however, that if judicial review is to play a central role in the state's supervisory system, it must at least measure the allegedly state-endorsed private conduct against the state standards that are claimed to replace competition.

¹² Sections 411 and 412 of that statute immunize private parties who participate in peer review from state and federal antitrust damage actions if the professional review action is taken in the "reasonable belief that the action was in the furtherance of quality health care," after a reasonable effort to obtain the facts of the matter, after adequate notice and hearing procedures are provided, and in the "reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts." 100 Stat. 3784-3787. As noted above, however, the 1986 Act expressly preserves other, preexisting legal immunities. See pp. 6-7, *supra*.

b. The question whether Oregon's mandating peer review constitutes "clear articulation" under the first prong of the *Midcal* test is more difficult. It is entirely plausible that Oregon intended to displace some aspects of competition with a scheme of professional self-regulation, upon which scrutiny by a federal antitrust court—and the threat of treble damages—would be an unwarranted and inappropriate intrusion. But it is also entirely plausible that Oregon assumed that the antitrust laws would remain fully applicable and wished to encourage only conduct that would survive a "rule of reason" analysis.

The difficulty of the "clear articulation" issue in this case may be due, in part, to the absence of provisions for active supervision: if respondents or the court of appeals had pointed to some mechanisms for active supervision, the details of those mechanisms might provide additional clues about the extent to which the legislature intended to displace the competition that the Sherman Act is designed to foster. See 1 P. Areeda & D. Turner, *Antitrust Law* § 212c, at 71 (1978) (stressing "interrelationship" of "adequate public supervision" and "clear state purpose to displace antitrust law" criteria). Since the absence of "active supervision" enables the Court to decide this case without deciding the clear articulation issue, we suggest that the Court may wish to defer further development of the law of clear articulation to a future case.

CONCLUSION

The petition for a writ of certiorari should be granted as to the first question presented.

Respectfully submitted.

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JULY 1987

AMICUS CURIAE

BRIEF

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PATRICK MEYER, M.D.,
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RICHARD C. HARRIS, M.D.,
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and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE;
BRIEF AMICI CURIAE OF THE JOINT COMMISSION
ON ACCREDITATION OF HOSPITALS, AMERICAN
HOSPITAL ASSOCIATION, AMERICAN MEDICAL
ASSOCIATION, OREGON ASSOCIATION OF HOSPITALS,
AND OREGON MEDICAL ASSOCIATION IN OPPOSITION
TO THE PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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February 9, 1987

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In The
Supreme Court of the United States
October Term, 1986

TIMOTHY A. PATRICK, M.D.,

Petitioner,

v.

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTLEKAMP, M.D.,
PATRICK MEYER, M.D.,
GARY M. BOELLING, M.D.,
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DANIEL M. RAPPAPORT, M.D.,
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doing business as ASTORIA CLINIC,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF AMICI
CURIAE IN OPPOSITION TO THE PETITION
FOR A WRIT OF CERTIORARI TO THE UNITED
STATES COURT OF APPEALS FOR THE
NINTH CIRCUIT

The Joint Commission on Accreditation of Hospitals, the American Hospital Association, the American Medical Association, the Oregon Association of Hospitals and the Oregon Medical Association respectfully move for leave to file the attached brief *amici curiae* in opposition to the Petitioner's request that a writ of certiorari issue to the United States Court Of Appeals for the Ninth Circuit. The

consent of counsel for the Petitioner to the filing of this brief *amici curiae* has been requested but refused. The consent of counsel for the Respondents has been granted.

The Joint Commission on Accreditation of Hospitals, the American Hospital Association, the American Medical Association, the Oregon Association of Hospitals and the Oregon Medical Association represent major national and other organizations in the United States concerned with medical and hospital care. Their interest in this matter arises from their devotion to seeking the highest possible quality health care; their dedication to good hospital and medical practice; and their commitment to ensuring that physicians can conduct effective peer review according to their best clinical judgment and professional standards. This brief concentrates on broad policy issues relating to hospital peer review in the United States.

Respectfully submitted,

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 Hospitals,
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 American Medical Association,
 Oregon Association of Hospitals, and
 Oregon Medical Association

In The
 Supreme Court of the United States
 October Term, 1986

TIMOTHY A. PATRICK, M.D.,

Petitioner,

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BRIEF AMICI CURIAE OF THE JOINT COMMISSION
 ON ACCREDITATION OF HOSPITALS, AMERICAN
 HOSPITAL ASSOCIATION, AMERICAN MEDICAL
 ASSOCIATION, OREGON ASSOCIATION OF HOSPITALS,
 AND OREGON MEDICAL ASSOCIATION IN OPPOSITION
 TO THE PETITION FOR A WRIT OF CERTIORARI TO
 THE UNITED STATES COURT OF APPEALS
 FOR THE NINTH CIRCUIT

INTEREST OF AMICI CURIAE

Amici curiae represent major national and other organizations in the United States concerned with medical and hospital care. Each *amicus* is dedicated to promoting the public welfare by maintaining high professional health care standards and quality hospital and medical

care through effective professional peer review. The organizations herein represented are:

(1) The Joint Commission on Accreditation of Hospitals ("JCAH") is comprised of the following member organizations: American Hospital Association, American Medical Association, American College of Surgeons, American College of Physicians and American Dental Association. The JCAH is the primary private hospital accreditation body in the United States and accredits more than 5,000 hospitals nationwide on the basis of substantial compliance with its standards. For the purpose of providing hospital services eligible for payment under the federal Medicare program, 42 U.S.C. § 1395x(e) defines an eligible hospital to include *inter alia* an institution that "is accredited by the Joint Commission on Accreditation of Hospitals." JCAH standards require each individual hospital to police its own medical staff through an internal system of professional peer review; the Conditions of Participation of the federal Medicare program contain similar requirements. 42 C.F.R. § 482.22. The Health Division in the State of Oregon pursuant to Or. Rev. Stat. 441.055, may accept certification by the JCAH as evidence of compliance with Oregon state hospital standards. JCAH is concerned with the grave importance of medical peer review activity to the JCAH mission of promoting quality health care in hospitals.

(2) The American Hospital Association ("AHA") was founded in 1898 and is the primary organization of hospitals in the United States. It is a non-profit membership corporation whose principal corporate objective is to promote the welfare of the public through leadership and through assistance to its members in the provision of better health care and services for all people. AHA's membership includes approximately 6,000 hospitals and other health care institutions, as well as approximately 35,000 individuals.

(3) The American Medical Association ("AMA") was

established in 1847 to promote the science and art of medicine. It is a federation of fifty state medical associations, the medical associations of three United States territories and of the District of Columbia, each being a self-governing autonomous entity. The AMA is the largest medical organization in the world and has approximately 275,000 members.

(4) The Oregon Association of Hospitals ("OAH") is an allied state association of the AHA and shares the commitment to furthering high quality health care and services. The OAH is a voluntary association whose members are 78 Oregon hospitals, including every private and public general hospital in the state.

(5) The Oregon Medical Association ("OMA") is a constituent state medical association within the federation of the AMA and includes component county and district medical societies and more than 4,000 members. Physician adversaries in this litigation are members of OMA. In common with the AMA, OMA is dedicated to advancing the science and art of medicine and the improvement of public health.

Amici's interest arises from their devotion to seeking the highest possible quality health care; their dedication to good hospital and medical practice; and their commitment to ensuring that physicians can conduct effective peer review according to their best clinical judgment and professional standards, uninhibited by the fear of uninsurable risks and the threat of antitrust litigation.

STATEMENT OF FACTS

The parties have presented the facts of this case to the Court in the petition and the brief in opposition. The opinion of the United States Court of Appeals for the Ninth Circuit contains a statement of the evidence in the light most favorable to Petitioner. *Patrick v. Burget*, 800 F.2d 1498, 1502 n.1 (9th Cir. 1986). The Ninth Circuit reversed the district court jury verdict in favor of Petitioner on Sherman Act and Oregon state law claims, and remanded to the district court "for determination of whether Patrick has antitrust claims that survive and for a new trial on the state law claim." *Id.* at 1502.

REASONS FOR DENYING THE WRIT

I. An Opinion Of The Supreme Court In This Action Would Have Limited Prospective Application Because Of Enactment Of The Health Care Quality Improvement Act Of 1986.

In November 1986, the President signed into law the Health Care Quality Improvement Act of 1986.¹ This legislation, which was actively supported by the hospital industry and the medical profession, provides important and much-needed protection for those engaged in peer review and generally shields against liability for damages in federal antitrust actions, among others. The statute also establishes a federal clearinghouse for information concerning disciplinary actions against physicians by hospitals and state licensing authorities.

In Section 402 of the Act, Congress sets forth the specific finding that:

The threat of private money damage liability un-

¹The Health Care Quality Improvement Act of 1986, Title IV (Encouraging Good Faith Professional Review Activities) of the State Comprehensive Mental Health Services Plan Act of 1986, Pub. L. No. 99-660, January, 1987 U.S. Code Cong. & Ad. News.

der Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

As expressed in this statute, the clear intent of Congress is to discourage the application of federal antitrust law in resolving disputes arising out of the peer review of professional competence and performance. The legislation signifies recognition that effective and uninhibited peer review is essential to maintaining quality patient care, and to identifying and dealing with practitioners whose care is substandard. At the same time, the Act promotes fairness by providing meaningful guidelines of due process for those who are the subject of peer review proceedings in hospitals.

This statute, and its construction with the Clayton Act and the Sherman Act, will be taken into account in federal peer review antitrust litigation and in state peer review litigation arising subsequent to its passage. As the statute is prospective in nature, it is inapplicable to this action, which is one of the last peer review cases decided by the lower courts before enactment of the statute.

Undoubtedly, this Court will be requested by litigants in future peer review antitrust cases to construe the Health Care Quality Improvement Act of 1986 with the Clayton Act and the Sherman Act. Since construction of the Act is not presented in this action, any opinion of this Court would have limited prospective application. Rather than grant certiorari in this action, the Court therefore should defer consideration of these matters until presented in an appropriate peer review antitrust case that arises after enactment of the Health Care Quality Improvement Act of 1986.

II. The Court Of Appeals Correctly Held That The Peer Review Activities Of The Defendants Were Exempt From Antitrust Scrutiny Under The State Action Doctrine.

This Court has held that Congress did not intend the federal antitrust laws to reach activity required by the states, and that individuals engaged in otherwise anticompetitive conduct are exempt when that conduct is taken pursuant to a clearly articulated state policy and subject to supervision by the state. *Parker v. Brown*, 317 U.S. 341 (1943); *Southern Motor Carriers Rate Conference, Inc. v. U.S.*, 471 U.S. —, 105 S. Ct. 1721 (1985). The Ninth Circuit found these prerequisites satisfied by operation of Oregon's extensive statutory and regulatory scheme relating to professional peer review *inter alia* in the state's hospital licensing requirements, peer review immunity statute, and rules and regulations promulgated thereunder. *See Patrick*, 800 F.2d at 1505-07. The Ninth Circuit correctly held that under the Oregon statutory scheme, peer review qualifies for state action immunity. *Id.* at 1501-02.

The state action exemption involves questions of federalism and constitutional structure relating to how far our national competition policy should be extended to cover local matters that are regulated by the states. In this context, a narrow reading of the state action doctrine is appropriate only when federal antitrust policies are believed to outweigh the values of federalism.

It is abundantly clear that Oregon state policy, as well as that of the other states, strongly supports protection from federal antitrust liability for activities designed to improve standards of professional competence and to elevate the quality of care available to the public. Similarly, enactment of the Health Care Quality Improvement Act of 1986 indicates a clear intent by Congress to protect peer review participants and activities. The Ninth Circuit decision invoking state action is consistent with the policy of

protecting peer review and recognizing its importance to the states and to society. The decision of the Ninth Circuit need not be reviewed.

III. Peer Review Promotes Professional Competence And Must Be Encouraged If The Rising Incidence Of Malpractice Claims Is To Be Dealt With Effectively.

The rapidly increasing incidence of malpractice claims, both in size and number, has reached a state of crisis in the United States. More than four out of five malpractice claims originate from treatment provided in hospitals. Some of these claims are legally or medically justified, but many are not; some involve incidents that might have been avoided if incompetent or impaired physicians had been appropriately sanctioned or denied access to hospital facilities. The public traditionally has looked to the hospital industry and the medical profession to dedicate their resources to combating this situation, and this reliance has been reaffirmed by Congress in the Health Care Quality Improvement Act of 1986.

Effective peer review is the mechanism through which health care providers seek to assure quality control in the services delivered, and is a crucial means to protect the public from incompetent and negligent health care practitioners. Moreover, meaningful peer review is essential if the intensifying crisis in malpractice claims is to be controlled. To the extent that the peer review process identifies and effectively deals with practitioners whose patient care is substandard, it also operates to promote the availability and lower the cost of professional liability insurance. The hospital industry and the medical profession are engaged in a vigorous effort to encourage the further development of a system of peer review that fosters professional competence and deals effectively with incompetent and impaired health care practitioners.

If the state action defense is narrowly construed, as

urged by Petitioner, malpractice prone physicians will have a greater ability to use the threat of antitrust litigation to thwart peer review scrutiny of their performance. This is contrary to state policies strongly favoring effective peer review and contrary to Congressional intent as expressed in the Health Care Quality Improvement Act of 1986.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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SUPPLEMENTAL

BRIEF

SEP 8 1987

JOSEPH F. SPANIOL, JR.
CLERK

**In the Supreme Court
of the United States**

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, M.D.,
Petitioner,
v.

WILLIAM M. BURGET, M.D.,
JORMA M. LEINASSAR, M.D.,
R. G. KETTELKAMP, M.D.,
PATRICK MEYER, M.D.,
GARY M. BOELLING, M.D.,
ROBERT D. NEIKES, M.D.,
FRANKLIN D. RUSSELL, M.D.,
LEIGH C. DOLIN, M.D.,
RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,
Respondents.

RESPONDENTS' SUPPLEMENTAL BRIEF
IN OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

NO. 86-1145

Timothy A. Patrick, M.D.
Petitioner,

v.

William M. Burget, M.D.,
Jorma M. Leinassar, M.D.,
R. G. Kettelkamp, M.D.,
Patrick Meyer, M.D.,
Gary M. Boelling, M.D.,
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Richard C. Harris, M.D.,
Daniel M. Rappaport, M.D.,
and Tzu Sung Chiang, M.D.,
doing business as Astoria Clinic,
Respondents.

RESPONDENTS' SUPPLEMENTAL BRIEF IN
OPPOSITION TO
PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Pursuant to the provisions of Sup. Ct. R. 22.6, Respondents submit this Supplemental Brief addressing two matters:

1. The recent decision of the Seventh Circuit in Tambone v. Memorial Hospital for McHenry County, 1987-1 Trade Cases, ¶ 67,634 (7th Cir.); and

2. A response, in part, to the Amicus Curiae Brief submitted by the Solicitor General.

1.

The Tambone Decision

In Tambone v. Memorial Hospital for McHenry County, 1987-1 Trade Cases, ¶ 67,634 (7th Cir. 1987) (hereinafter "Tambone"), pursuant to the standards established by this Court in California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97 (1980), the Seventh Circuit determined whether peer review in the State of Illinois is sheltered from antitrust

liability by reason of the state action doctrine. Of course, the Seventh Circuit applied the two-prong litmus test of California Liquor Dealers v. Midcal Aluminum, supra. It then proceeded to analyze Illinois law. After a facial review of the statutes, it found inadequate indicia of active state supervision.

The significance of Tambone, supra, is two-fold:

First, if mandatory reporting of hospital-based peer review to the Illinois State Medical Disciplinary Board were statutorily required, the active supervision component would be satisfied. Of course, in the instant case, such mandatory reporting has been required at all times by the State of Oregon. ORS 441.820 (1). Thus the decision of the Seventh Circuit is directly supportive of the Ninth Circuit's decision in this case.

Second, the Tambone, supra, decision demonstrates that the Circuits are doing an adequate and careful job of interpreting state law in light of this Court's Midcal standards. Indeed the Seventh Circuit has held, in a series of cases interpreting the law of Indiana, that state action immunity was available to persons engaged in hospital-based peer review. Maresse v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. denied, 105 S.Ct. 3501 (1985); Doe v. St. Joseph's Hospital, 788 F.2d 411 (7th Cir. 1986); and Ezpeleta v. Sisters of Mercy Health Corp., 800 F.2d 119 (7th Cir. 1986). The same Circuit has reached different outcomes based exclusively upon the law of different states. Should this Court accept certiorari in the instant case to review the Ninth Circuit's interpretation of Oregon law, it would extend an invitation

to review the discrete statutes of each and every other state that provides some statutory variant of peer review.

2.

The Amicus Brief Filed ByThe Solicitor General

Pursuant to invitation by this Court, extended on March 2, 1987, the Office of the Solicitor General has filed an Amicus Brief. The primary thrust of this Brief is to question the Ninth Circuit's interpretation of Oregon law to the effect that Oregon's statutes, administrative rules, and common law provide for active supervision. Respondents will not offer a response to the Solicitor General's conclusions with respect to administrative supervision (Pet. Br. pp. 31-35). It does appear appropriate to specifically challenge the Solicitor General's argument that Oregon does not

actively supervise privilege termination proceedings through judicial review (Amicus Br. p. 12).

First, the Court will note that the chief legal officer of the State of Oregon, Attorney General David Frohnmayer, filed an Amicus Brief in support of Respondents with the Ninth Circuit. With respect to judicial, as opposed to administrative, supervision, the Attorney General of Oregon concluded:

"* * * However, Oregon concludes that under ORS 441.055(3)(c) court review would be available at least for a restriction or termination of privileges, and at least to review fairness of the procedure and compliance with Health Division requirements. This assurance of review by the judicial branch should be sufficient alone to qualify as adequate state supervision.
* * *."

Amicus Brief of Attorney General
p. 32.

Additionally, the Solicitor General, in his cursory analysis of the

availability of judicial review concerning restriction or termination of privileges, failed to bring this Court's attention to the following matters:

A. ORS 41.675 permits the use of otherwise privileged and inadmissible evidence related to hospital-based peer review in

"* * * judicial proceedings in which a health care practitioner contests the denial, restriction or termination of clinical privileges by a health care facility. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding."

It is not possible to read this statute without recognizing the legislative intent to permit judicial review of limitations upon clinical privileges.

B. Second, in this very case, the trial court granted a state-based remedy, i.e. interference with prospective advantage, arising directly and squarely

out of the peer review process. In this connection plaintiff's Second Amended Complaint prayed for injunctive relief:

"* * * requiring plaintiff Patrick's reinstatement to full privilege status on the medical staff of Columbia Memorial Hospital;"

Thus, the petitioner here interpreted Oregon law to permit full status quo restoration. Petitioner voluntarily settled prior to trial with the Hospital and thus made this issue moot.

C. Third, the Oregon antitrust laws grant judicial review to hospital-based peer review. ORS 646.725-730. In analogous circumstances under the provisions of the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq., the courts have held that adequate regulation exists if a state has antitrust laws which permit judicial review of alleged misconduct. Sanborn v. Palm, 336

F. Supp. 222, 228 (U.S.D.C. Tex. 1971); Professional & Business Mens L.I. Co. v. Bankers Life Co., 163 F. Supp. 274, 280 (D. Montana 1958).

Thus, in addition to the administrative supervision described in Respondent's initial Brief (pp. 31-35), there is clear and convincing evidence of active state supervision through the medium of judicial review.

Conclusion

Respondents pray that the Court deny grant of the Writ of Certiorari.

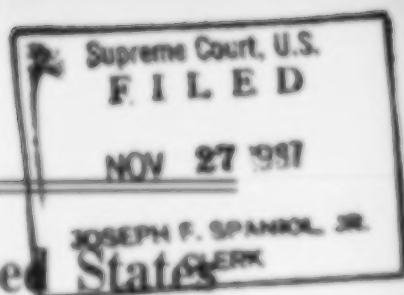
Respectfully submitted,

SCHWABE, WILLIAMSON & WYATT

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Thomas M. Triplett
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JOINT APPENDIX

1
No. 86-1145



In The
Supreme Court of the United States

October Term, 1987

— o —
TIMOTHY A. PATRICK, M.D.,

Petitioner,

v.

WILLIAM M. BURGET, M.D., JEFFREY M. LEINASSAR, AS PERSONAL REPRESENTATIVE OF JORMA M. LEINASSAR, M.D., DECEASED, R.G. KETTLEKAMP, M.D., PATRICK MEYER, M.D., GARY M. BOELLING, M.D., ROBERT D. NEIKES, M.D., FRANKLIN D. RUSSELL, M.D., LEIGH C. DOLIN, M.D., RICHARD C. HARRIS, M.D., DANIEL M. RAPPA-PORT, M.D., and TZU SUNG CHIANG, M.D., DOING BUSINESS AS ASTORIA CLINIC,

Respondents.

— o —
On Petition for Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

— o —
JOINT APPENDIX
— o —

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PETITION FOR CERTIORARI FILED JANUARY 9, 1987
CERTIORARI GRANTED OCTOBER 5, 1987

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- March 24, 1981—Patrick files antitrust complaint against defendants in U.S. District Court for the District of Oregon.
- August 3, 1983—Patrick files second amended and supplemental complaint.
- August 10, 1983—Defendants file their answer to the second amended and supplemental complaint.
- November 26, 1984—Amended pre-trial order filed.
- November 30, 1984—Jury trial begins.
- December 22, 1984—Jury returns verdict in favor of Patrick.
- January 7, 1985—District Court enters judgment on the verdict.
- March 27, 1985—District Court denies defendants' motions for judgment NOV or new trial.
- April 4, 1985—Defendants file notice of appeal to the Court of Appeals for the Ninth Circuit.
- September 30, 1986—Court of Appeals issues opinion reversing the judgment below. (The opinion is reproduced in the petition for certiorari.)
- November 26, 1986—Court of Appeals denies Patrick's petition for rehearing.
-

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

TIMOTHY A. PATRICK, M.D.,)
and ASTORIA SURGICAL)
CENTER, P.C.,)

Plaintiffs,)

vs.)

WILLIAM M. BURGET, M.D.,)
JORMA M. LEINASSAR, M.D.,)
LEROY W. STEINMANN, M.D.,)
R. G. KETTLEKAMP, M.D.,)
PATRICK MEYER, M.D.,)
GARY M. BOELLING, M.D.,)
ROBERT D. NEIKES, M.D.,)
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LEIGH C. DOLIN, M.D.,)
RICHARD C. HARRIS, M.D.,)
DANIEL M. RAPPAPORT, M.D.,)
and TZU SUNG CHIANG, M.D.,)
doing business as ASTORIA)

CLINIC, and COLUMBIA)
LUTHERAN CHARITIES, an)
Oregon corporation, doing)
business as COLUMBIA)
MEMORIAL HOSPITAL,)

Defendants.)

CIVIL NO.
81-260 BU

SECOND
AMENDED AND
SUPPLEMENTAL
COMPLAINT

(Antitrust
Violations;
Interference with
Professional
Relations)

DEMAND FOR
JURY TRIAL

FIRST CLAIM FOR RELIEF

(Federal Law)

1. Plaintiff Timothy A. Patrick is a physician, a Diplomate of the American Board of Surgery, and is licensed to practice medicine in the State of Oregon. He has carried on a surgery practice in Astoria, Oregon from

1972 until the present. He has practiced as a professional corporation since February 25, 1975. It was called Timothy A. Patrick, M.D. P.C. from then until April 1, 1980 when its name was changed to Astoria Surgical Center, P.C.

2. The individual defendants are physicians licensed to practice medicine by the State of Oregon, and who, at times material herein, practiced together in Astoria under the assumed business name of Astoria Clinic. The corporate defendant, Columbia Lutheran Charities, is an Oregon corporation doing business as Columbia Memorial Hospital (hereinafter "Hospital"), and is the only hospital in Astoria.

3. This action is brought pursuant to § 1 and § 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The Court has jurisdiction pursuant to 28 U.S.C. § 1337.

4. The relevant line of commerce is the practice of general, vascular and thoracic surgery. At all material times plaintiffs were in direct competition with the individual defendants, in that defendant Richard C. Harris, M.D., also practiced general, vascular and thoracic surgery and shared fees thereby earned with the other individual defendants, and Dr. Harris' successor now does likewise.

5. The relevant geographic market is northern Clatsop County, Oregon, and the southern part of Pacific County, Washington. Substantial numbers of people from each county consult plaintiffs or defendants for advice and treatment.

6. The amount of commerce is substantial. Total surgical fees in the relevant market exceed \$1,000,000 per year, a substantial part of which is received from Washington

residents. The practice of surgery within the relevant market affects interstate commerce, in that a substantial quantity of medical equipment and supplies is purchased from manufacturers in other states, and substantial amounts of income are received from out-of-state sources, such as Medicare, Medicaid and insurers.

7. Beginning approximately July 15, 1973, when plaintiff ended his employment agreement with the Astoria Clinic, and continuing through the present, defendants have combined and conspired among themselves and with others, including Drs. Paul D. Stull and Chester S. McLaughlin, to restrain competition in and to monopolize the practice of surgery within the relevant market, in violation of §§ 1 and 2 of the Sherman Act.

8. In furtherance of the combination and conspiracy, and with the purpose and intent of excluding plaintiff from the market and destroying competition from him, the individual defendants have:

- A. Attempted to curtail or eliminate plaintiff's surgical privileges at the Hospital; and, as of April 8, 1982, did cause plaintiff Patrick's surgical privileges at the Hospital to be terminated;
- B. Attempted to cause and have caused, the Oregon State Board of Medical Examiners to take disciplinary action against plaintiff Patrick by making false accusations against him;
- C. Attempted to cause, and have caused, the Hospital to take disciplinary action against plaintiff Patrick by making false accusations against him;
- D. Defamed plaintiff Patrick's skill and qualifications as a surgeon within the relevant market;

- E. Interfered with the granting of full surgical privileges at the Hospital to plaintiffs' surgical associate, Dr. James K. Weber;
 - F. Caused Astoria Clinic physicians to dominate all Hospital policy making committees and offices and to place plaintiffs and their associate in a false light;
 - G. Caused the Hospital to discriminate against plaintiffs in the rendition of the services that the Hospital performs for physicians;
 - H. Caused the Hospital to discriminate against plaintiffs in the manner of reviewing surgical cases, in that they caused the Hospital to review the surgical cases of Drs. Harris, Stull and McLaughlin in a manner which sheltered their practices from critical review;
 - I. Caused the Hospital to discriminate against plaintiffs in the referral of patients needing surgery, so that the Hospital regularly referred patients to Dr. Harris rather than to plaintiffs;
 - J. Refused to provide other medical services to patients who consult plaintiffs for surgery, and otherwise prevented plaintiffs from treating patients whom they regard as their own;
 - K. Caused the Hospital to divert patients of plaintiffs to other physicians;
 - L. Caused the Hospital to refuse to employ plaintiff Patrick's wife as operating room nurse; and
 - M. Refused to extend normal professional courtesies to plaintiffs in the care of their patients.
9. The individual defendants have attempted to monopolize the practice of surgery within the relevant market by the acts described in paragraph 8, all with the specific intent of weakening or eliminating competition from

plaintiffs, and the defendant Hospital has conspired in that attempt. The individual defendants constitute twelve of twenty physicians practicing in Astoria, and thereby dominate both the practice of medicine in the relevant market and the policy and practices of the Hospital. By reason of such dominance, and by reason of their predatory practices described above, defendants' attempt to monopolize the practice of surgery has a dangerous probability of success.

10. Plaintiffs have been damaged in the amount of \$2,250,000.00, within the four years preceding the filing of this action.

11. Plaintiffs will continue to suffer damage, unless defendants are restrained.

12. Defendants' actions have harmed and threaten to harm the general public by interfering with the orderly practice of medicine in the community, by reducing the number of surgeons practicing in the community, and by depriving patients of the quality of medical care they would receive but for defendants' actions against plaintiff.

SECOND CLAIM FOR RELIEF (Oregon Law)

13. Plaintiffs reallege paragraphs 1 and 2 and 4 through 12 of the First Claim for Relief.

14. Defendants' acts are in violation of ORS 646.725 and 646.730.

THIRD CLAIM FOR RELIEF

15. Plaintiffs reallege paragraphs 1, 2, 7, 8, 10 and 12 above.

16. The actions of the individual defendants constitute tortious interference with plaintiffs' professional, business, and economic relationships with the Hospital, current and prospective patients, and the community. The actions of the defendant Hospital tortiously interfered with plaintiffs' professional business and economic relationships with current and prospective patients and with the community.

WHEREFORE, plaintiffs demand judgment as follows:

A. Upon the First Claim, in the amount of \$2,250,000 trebled to \$6,750,000;

B. Alternatively, upon the Second Claim, in the amount of \$2,250,000, trebled to \$6,750,000;

C. Upon the Third Claim, in the amount of \$2,250,000 general damages and \$4,000,000 punitive damages;

D. For injunctive relief prohibiting defendants from restraining competition and attempting to monopolize the practice of surgery within the relevant market, and requiring plaintiff Patrick's reinstatement to full privileged status on the medical staff of Columbia Memorial Hospital;

E. For reasonable attorneys' fees in the amount of \$100,000.

F. For his costs and disbursements herein.

G. For such other relief as may be appropriate.

TONKON, TORP, GALEN,
MARMADUKE & BOOTH

/s/ By Don H. Marmaduke
Don H. Marmaduke
Attorneys for Plaintiffs

PLAINTIFFS DEMAND TRIAL
BY JURY

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
(Caption omitted in printing)

ANSWER TO SECOND AMENDED AND
SUPPLEMENTAL COMPLAINT

CIVIL NO. 81-260 BU

Defendants William M. Burget, M.D., Jorma M. Leinassar, M.D., Leroy W. Steinmann, M.D., R. G. Kettlekamp, M.D., Patrick Meyer, M.D., Gary M. Boelling, M.D., Robert D. Neikes, M.D., Franklin D. Russell, M.D., Leigh C. Dolin, M.D., Richard C. Harris, M.D., Daniel M. Rappaport, M.D., and Tzu Sung Chiang, M.D., doing business as Astoria Clinic (hereinafter referred to as "These Defendants") for answer to plaintiffs' Second Amended And Supplemental Complaint, allege as follows:

FIRST CLAIM FOR RELIEF

I.

These Defendants admit the allegations of paragraph 1 of plaintiffs' first claim for relief.

II.

These Defendants deny the allegations of paragraph 2 of plaintiffs' first claim for relief.

III.

These Defendants admit that plaintiffs purport to bring this action pursuant to the provisions of the statutes referred to in paragraph 3 of plaintiffs' Second Amended and Supplemental Complaint. Except as expressly admitted, These Defendants deny each and every allegation

contained within paragraph 3 of plaintiffs' first claim for relief.

IV.

These Defendants deny each and every allegation contained in paragraph 4 of plaintiffs' first claim for relief.

V.

These Defendants deny each and every allegation contained in paragraph 5 of plaintiffs' first claim for relief.

VI.

These Defendants deny each and every allegation contained in paragraph 6 of plaintiffs' first claim for relief.

VII.

These Defendants deny each and every allegation contained in paragraph 7 of plaintiffs' first claim for relief.

VIII.

These Defendants deny each and every allegation contained in paragraph 8 of plaintiffs' first claim for relief.

IX.

These Defendants deny each and every allegation contained in paragraph 9 of plaintiff's first claim for relief.

X.

These Defendants deny each and every allegation contained in paragraph 10 of plaintiffs' first claim for relief.

XI.

These Defendants deny each and every allegation contained in paragraph 11 of plaintiffs' first claim for relief.

XII.

These Defendants deny each and every allegation contained in paragraph 12 of plaintiffs' first claim for relief.

SECOND CLAIM FOR RELIEF

XIII.

These Defendants reallege their answers to paragraph 1, 2, and 4 through 12 of their first claim for relief and incorporate them herein as if more fully set forth.

XIV.

These Defendants deny each and every allegation of paragraph 14 of plaintiffs' Second Amended and Supplemental Complaint.

THIRD CLAIM FOR RELIEF

XV.

These Defendants reallege their answers to paragraphs 1, 2, 7, 8, 10, and 12 of their first claim for relief and incorporate them herein as if more fully set forth.

XVI.

These Defendants deny each any every allegation of paragraph 16 of plaintiffs' Second Amended and Supplemental Complaint.

FOR THEIR FIRST AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XVII.

Plaintiffs' claims are barred in whole or in part by the applicable statute of limitations.

FOR THEIR SECOND AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XVIII.

This Court lacks subject matter jurisdiction.

FOR THEIR THIRD AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XIX

Plaintiffs' claims are barred in whole or in part by the state action doctrine.

FOR THEIR FOURTH AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XX.

Plaintiffs' claims are barred in whole or in part by the Noerr-Pennington Doctrine.

FOR THEIR FIFTH AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XXI.

Plaintiffs lack standing to assert some or all of the claims set forth in the Second Amended and Supplemental Complaint.

FOR THEIR SIXTH AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:

XXII.

Plaintiffs have failed to state a claim for relief.

WHEREFORE, These Defendants pray that plaintiffs' Second Amended and Supplemental Complaint be dismissed with prejudice and that judgment be entered in favor of These Defendants, and each of them, for their costs and disbursements incurred herein.

SCHWABE, WILLIAMSON, WYATT,
MOORE & ROBERTS

By: /s/ Thomas M. Triplett
Thomas M. Triplett
Attorneys for Defendants
Burget, Leinassar, Steinmann,
Kettlekamp, Meyer, Boelling,
Neikes, Russell, Dolin, Harris,
Rappaport, and Chiang, dba
Astoria Clinic

(Certificate of Service by Mail omitted in printing)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
(Caption omitted in printing)

AMENDED PRE-TRIAL ORDER

The following proposed Amended Pre-Trial Order is lodged with the Court pursuant to L.R. 235-2.

1. *Nature of the Action.*

This action is a federal antitrust case, with pendent state claims of Oregon antitrust law violations and tortious interference with business relationships. Plaintiff claims that defendants have combined and conspired to restrain trade and monopolize the market for surgical services in and around Astoria, Oregon, in violation of §§ 1 and 2 of the Sherman Act and of ORS 646.725 and 646.730, and that defendants have tortiously interfered with plaintiff's business and professional relationships with third parties. Trial will be by jury.

2. *Subject Matter Jurisdiction.*

Plaintiff asserts that this Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1337 with respect to its claims arising under Sections 1 and 2 of the Sherman Act. Plaintiff further asserts that this Court has pendent jurisdiction with respect to its claims arising under ORS 646.725 and ORS 646.730 and its claim of tortious interference.

3. *Agreed Facts as to Which Relevance is Not Disputed.*

a. Plaintiff Timothy A. Patrick, M.D. is a physician. Plaintiff Astoria Surgical Center, P.C. is Dr. Patrick's

professional corporation. Dr. Patrick has practiced as a professional corporation since February 25, 1975. The corporation was called Timothy A. Patrick, M.D., P.C. from then until April 3, 1980 when its name was changed to Astoria Surgical Center, P.C. Both plaintiffs will hereinafter be referred to collectively as "plaintiffs"; when "plaintiff" is used, it will refer to Dr. Patrick only.

Plaintiff's practice is primarily general, vascular and thoracic surgery. He has been licensed to practice in Oregon since July 1972. He has practiced as a surgeon in Astoria, Oregon from then until now.

b. The individually named defendants are physicians. They have practiced together as partners doing business as Astoria Clinic, or as employees of the partnership, in the City of Astoria, Oregon at various times during the period that plaintiff has practiced surgery there. The defendants' fields of practice, and the dates of their associations with the partnership, are as follow (hereinafter "Clinic defendants"):

William M. Burget, Internal Medicine	February 1, 1953
Jorma M. Leinassar, Internal Medicine	July 1, 1954 - February 3, 1984
Leroy W. Steinmann, General Practice	July 1, 1957
Richard G. Kettelkamp, General Practice and Obstetrics	July 1, 1963 - June 30, 1981
Gary M. Boelling, Internal Medicine	July 1, 1972
Robert D. Neikes, General Practice	July 1, 1972 - July 30, 1982

Franklin H. Russell, General Practice and Psychiatry	July 1, 1974 - June 24, 1983
Leigh C. Dolin, Internal Medicine	July 1, 1979
Richard C. Harris, General, Thoracic and Vascular Surgery	July 1, 1979 - February 25, 1982
Daniel M. Rappaport, Pediatrics	July 1, 1979
Tzu Sung Chiang, Obstetrics and Gynecology	February 1, 1981 - June 22, 1982
Patrick D. Meyer, Pediatrics	February 1, 1981

c. Columbia Memorial Hospital (hereinafter "Columbia Memorial" or the "Hospital") is a non-profit corporation, a licensed general hospital, and is accredited by the Joint Commission of Accreditation of Hospitals. Columbia Memorial is governed by a Board of Trustees. Under the direction of the Board of Trustees, the Hospital is administered by an Executive Director. Pursuant to ORS 441.055, the physicians with staff privileges at the Hospital are organized into a self-governing "medical staff" which is organized in conformity with written Bylaws, and which has various committees to supervise and monitor the provision of medical services. The medical staff Executive Committee consists of the officers of the medical staff, the chiefs of each clinical service, and one member elected at large. Trustees after recommendation from the medical staff. [sic] Reappointments are for periods of not more than two years. The clinical privileges that each staff member may exercise while practicing at the Hospital are considered every other year by the Executive Committee of the medical staff. The Executive Committee's recommendations then go to the Board for consideration. Plaintiff's appointment to the medical staff, and his clinical privileges as a surgeon member of the staff, were last approved in December 1980.

The Hospital's Bylaws incorporate a peer-review procedure as mandated by ORS 441.055(3). Any staff member's conduct may become the subject of a request for "corrective action" as provided in the Bylaws, a copy of which is attached and incorporated herein as Exhibit A. Such a request may be made by an officer of the medical staff, a chief of any service, the chairman of any standing committee of the medical staff, the Chief Executive Officer, or the Hospital's governing body.

d. On May 6, 1972, plaintiff submitted an application for staff privileges at the Hospital.

e. Columbia Memorial is the only hospital in Astoria. It primarily serves Clatsop County, Oregon, and the southern part of Pacific County, Washington. The Hospital's 1982 budget was \$10,867,000. It provides 65 beds. It budgeted 1460 patient-days per month in 1981. It presently employs a nonprofessional staff of about 142 full-time equivalents.

f. In July 1972, the Astoria Clinic hired plaintiff as a surgeon for a one year period. At the end of the year the Clinic offered plaintiff a partnership. Plaintiff declined. On July 21, 1973 he established an independent surgery practice in Astoria.

4. *Agreed Facts as to Which Relevance is Disputed.*

a. Plaintiff has held the following certifications and memberships from the dates indicated:

Certifications:

Diplomate, American Board of Surgery, 1977
Fellow, American College of Surgeons, 1978

Memberships:

Fellow, Society of Abdominal Surgeons, 1977
Fellow, Michael E. DeBakey International Cardiovascular Society, 1978
Fellow, Clinical Society of Vascular Surgeons, 1979

He has held the following professional positions, among others, during the periods noted:

Chief of Surgery, Columbia Memorial Hospital,
October 1978 through December 1979

President, Clatsop County Medical Society, 1973-1974

Trustee, Oregon Medical Association, 1973-1981

Member, Oregon Medical Association Executive Committee, 1973-1974

Trustee, Oregon Physicians Service Board, 1976-

President, Clatsop Chapter American Cancer Society, 1976

Clinical Instructor, Department of Family Practice, University of Oregon Health Science Center, 1976-1977

b. From at least 1972 to the present, the Astoria Clinic has not had among the firm's doctors an orthopedic surgeon, a urologist or a radiologist. Patients requiring specialized services in those fields have been referred to physicians outside the firm. Among those to whom referrals were made are Dr. C. S. McLaughlin, an orthopedist, and Dr. Paul D. Stull, a urologist. Both were Astoria physicians and Dr. Stull still is. Dr. McLaughlin left Astoria and entered the military service sometime in 1982. Some referrals were also made to Drs. Swanson and Foster by both the Astoria Clinic and plaintiffs. Dr. Swan-

son is an orthopedist who still practices in Astoria. Dr. Foster is also an orthopedist who now practices in New Mexico.

b. Plaintiff was the first, and is the only, surgeon who has left the Astoria Clinic who has stayed in Astoria and set up an independent surgery practice. All other surgeons who have left the Astoria Clinic have gone elsewhere to practice.

c. Plaintiff was the only general surgeon in Astoria who was independent of the Astoria Clinic from July 1973 until plaintiff hired Dr. James K. Weber as his associate in July 1979. From then until April 1981 they were the only independent general surgeons in Astoria. Dr. Weber commenced his own surgery practice there in April 1981, continuing until he left Astoria sometime in July of 1983.

d. Dr. Mark S. Stryker, whose specialty is Internal Medicine, was a partner in the Astoria Clinic throughout the period of time that plaintiff has been in Astoria, until Dr. Stryker's resignation from the partnership on February 1, 1981.

e. In April, 1979, defendant Frank Russell became chairman of the Investigative Committee of the Board of Medical Examiners for the State of Oregon. He had obtained an appointment to the Board in 1978. He served as chairman of the Investigative Committee for three consecutive years.

6. *Contentions of Fact.*

PLAINTIFFS

a. Approximately 20-25 percent of plaintiffs' patients are Washington residents. About 13-14 percent of the Astoria Clinic's patients come from Washington.

b. Plaintiffs' gross billings in the fiscal year ending February 28, 1981, were \$338,000, part of which was attributable to the work of an associate surgeon. Plaintiff's surgery at Columbia Memorial Hospital produced hospital revenues in excess of one million dollars annually during 1980 and 1981.

c. During 1980, 1981 and 1982 the physicians of the Astoria Clinic held voting control of the medical staff and of the Executive Committee of the Hospital. They also held the majority of the chairmanships of the clinical service committees.

d. Surgery has always been among the top revenue producing specialties among those practiced by physicians at the Astoria Clinic. The Astoria Clinic was dissatisfied with plaintiff's establishment of an independent surgery practice in Astoria. His competition with them caused the Astoria Clinic to adopt a policy of including non-competition clauses in their employment contracts with physicians. This was done uniformly from then on.

e. After plaintiff left the Astoria Clinic and began his own practice in Astoria, he was subjected to a variety of anti-competitive pressures from the Astoria Clinic, acting in concert with the Hospital's staff and Drs. McLaughlin and Stull. They included:

- 1) unwillingness to participate in reciprocal surgical coverage arrangements or to provide him surgical coverage during temporary absences from the city

- 2) coercion of Astoria Clinic patients who preferred to have plaintiff handle their surgical care

- 3) refusal to refer patients to plaintiff for surgical care during the absence of Astoria Clinic surgeons

4) discriminatory referrals to Astoria Clinic surgeons of the Hospital's Emergency Room patients who either expressed no preference for a particular surgeon or who expressed preference for plaintiff

5) unwillingness to have plaintiff assist Astoria Clinic surgeons in cases where some assistance was desirable

6) refused to provide professional consultation where the medical needs of plaintiff's patients required it

7) discriminatory and unfair peer review processes, e.g., defendant Harris caused plaintiff's surgical complications to be reviewed but avoided review of many of his own by omitting to mention them in hospital discharge summaries; defendant Harris reviewed plaintiff's cases but used his position as Chief of Surgery in 1980 to prevent plaintiff from reviewing his for a six-month period; defendant Harris and Drs. Stull and McLaughlin, who were not in substantial competition with each other because of the nature of their specialties, sheltered each other's practice from critical review

8) refusal to consider plaintiff's specific concerns regarding patient management in certain cases, and dismissing without investigation other concerns that he reported in his capacity as Chief of Surgery

9) refusal to hire Sandra Patrick as an operating room nurse when one was needed and she was ready, willing and able to fill the need, because she was plaintiff's wife

10) favoring defendants in hospital and administrative services

11) while Dr. Weber was associated with plaintiff, unnecessarily prolonging his probationary status, as a medical staff member, and referring to the Board of Medical Examiners, without investigation or consider-

ation according to the Bylaws, matters relating to his professional conduct

12) withdrawing plaintiff's privileges to record and interpret x-ray studies that he had performed for his patients for about eight years

13) favoring defendant Russell over plaintiff in PSRO review.

f. In July 1979, plaintiff increased his capacity to compete for surgery in the Astoria region by hiring an associate surgeon, Dr. James K. Weber. The Clinic defendants were experiencing increased economic pressure in their practice. Unemployment in Astoria was up and the economy was down. The Clinic defendants had previously embarked upon a new building and property acquisition program that was being financed by borrowing \$1,464,000 from the bank. Defendant Kettelkamp and Dr. Stryker declined to participate in the building partnership that underwrote the loan, but defendants Burget, Leinassar, Steinman, Russell, Boelling, Dolin and Meyer committed themselves to it. By 1979 the new building and property program had caused defendants' rent to increase from about \$6,000 to \$16,000 per month and their overhead to go from 50 to 56 percent.

g. In November, 1979, the Executive Committee of the Hospital considered a complaint that plaintiff and his associate, Dr. Weber, had failed to provide adequate coverage for their surgical patient, Leroy Willie, while they were temporarily away from Astoria. The Executive Committee referred the matter to the Board of Medical Examiners for possible further investigation. This issue was not handled in accordance with the procedures set forth in the Hospital's Bylaws. Instead, the Willie case and a

number of other cases of plaintiff's were taken to defendant Russell's Investigation Committee. The committee consisted of defendant Russell, Chairman, and Drs. Wilbur L. E. Larson and Anthony J. Cortese.

h. Defendants Harris and Boelling, together with Drs. McLaughlin and Stull, appeared before defendant Russell's Investigative Committee and gave ex parte testimony critical of plaintiff's and Dr. Weber's management of some 15 cases. Plaintiff and his associate were not informed of what cases were being investigated, who was giving testimony, what was being alleged, nor given any opportunity to respond or explain.

i. On January 2, 1980, plaintiff and Dr. Weber were required to appear before defendant Russell's Investigative Committee and to explain their handling of the Willie case. They were refused information as to other cases under investigation and given no opportunity to provide information on them. Defendant Russell purported to disqualify himself for conflict of interest at the beginning of the meeting. He represented that he would not participate in any discussions concerning the matter.

j. On January 10, 1980, plaintiff and his associate Dr. Weber were required to appear before the Board of Medical Examiners and explain their handling of the Leroy Willie case. No other cases were discussed. Defendant Russell purported to disqualify himself from all discussions.

k. On April 21, 1980, a letter of reprimand was issued by the Board of Medical Examiners to plaintiff and Dr. Weber over the signature of its Chairman, Dr. August

tus M. Tanaka. Unbeknownst to plaintiff or Dr. Weber, the letter was in fact written by defendant Russell with the aid of the Board's Executive Director, John Ulwelling. The letter criticized plaintiff's management of and care for 15 patients, including Leroy Willie, and accused him of medical carelessness. It was sent to all board members, the Columbia Memorial Hospital's Administrator, Chairman of the Board and Chief of Staff.

l. Plaintiff demanded and thereafter was given the identities of the patients considered by the Board of Medical Examiners Investigative Committee. He characterized the decision in the Willie case as "fair" but asked the Board for retraction or for a hearing with respect to the other 14 cases. Defendant Russell advocated against both of plaintiff's requests and neither was granted.

m. On September 2, 1980, Dr. Tanaka, Chairman of the Board of Medical Examiners, and a surgical consultant to the Board of Medical Examiners, Dr. Jack E. Battalia, reviewed with plaintiff the cases referred to in the Board's letter of April 21, 1980. They said that they would recommend revision of the Board's letter.

n. When plaintiff received neither correction of the Board's letter, nor a hearing on the 14 cases alluded to therein, plaintiff sued for judicial review and damages on March 13, 1981.

o. Most of the criticism in the letter was without foundation. On December 2, 1981, the Board of Medical Examiners retracted the April 21, 1980, letter in its entirety.

p. On June 9, 1980, defendant Harris requested the Executive Committee of the Hospital to recommend revo-

cation of plaintiff's thoracic surgery privileges. The Board of Medical Examiner's investigation and its reprimand letter to him were cited by defendant Harris in support of the proposed action. A number of plaintiff's thoracic surgery charts were referred to the Oregon Medical Association for review by thoracic surgery consultants. The Oregon Medical Association has made no recommendation concerning plaintiff's thoracic surgery practice.

q. On January 14, 1981, defendant Harris requested the Executive Committee to take corrective action against plaintiff pursuant to the Bylaws. Among the grounds cited to support the proposed action, defendant Harris specified the existence of the pending investigation of plaintiff's thoracic privileges and the occurrence of the Board of Medical Examiners' investigations.

r. On March 16, 1981, on motion of defendant Frank Russell, in his capacity as a member of the Executive Committee, the Executive Committee voted to recommend revocation of plaintiff's clinical privileges at Columbia Memorial Hospital.

s. Only one of plaintiff's cases, that of Stuart Snodgrass, was discussed by the Executive Committee on March 16, 1981, before it voted to revoke plaintiff's hospital privileges.

t. On April 1, 1981, at a meeting held in the Board Room of the Astoria Clinic, a notice of charges against plaintiff was drafted for the signature of the Hospital's chief administrator. Defendants Harris and Kettlekamp were involved in the meeting. Twenty-one patient-charts were cited as representative charts relied upon by the Ex-

ecutive Committee. Some were not plaintiff's patients. Most of the others involved situations that plaintiff handled as competently and carefully as others on the medical staff would have handled them, and as they had handled similar cases.

u. An Ad Hoc review committee was appointed to try the merits of the Executive Committee's recommendation that plaintiff's hospital privileges be revoked. Ten of plaintiff's patient-charts were used to support the Executive Committee's charges. They spanned a period from 1972 to 1980. As finally constituted, the Ad Hoc review committee was comprised of:

Defendant Dr. Gary M. Boelling, Chairman
Former Clinic Member Dr. Mark B. Stryker
Defendant Dr. Tzu Sung Chiang
Dr. Daniel Devine, and
Dr. Charles Browning

Defendant Boelling was appointed to the Ad Hoc review committee by the Executive Committee on July 1, 1981. The previous chairman resigned June 19, 1981.

v. The hearing was conducted in an unfair, biased manner calculated only to substantiate a recommendation to revoke plaintiff's privileges rather than to elicit the true facts and determine whether his practice was indeed below the standards and aims of the medical staff.

w. At the hearing plaintiff requested Drs. Boelling, Stryker, Chiang and Devine to give testimony on relevant facts within their first-hand knowledge, and on issues of their prejudgment, bias and partiality. Each of them refused to give any testimony on either subject.

x. Plaintiff then, on April 8, 1982, submitted his written resignation from the medical staff.

y. Twice before the Ad Hoc review committee began its proceedings, and twice after the proceedings terminated, plaintiff appealed to the Hospital's Board of Trustees to take steps to assure him of a fair and impartial determination of the charges against him; the Board refused to do so.

z. Plaintiff did not discover, until Dr. Boelling's deposition was taken in November, 1982, that defendant Boelling had given testimony against plaintiff to defendant Russell's Investigative Committee on some of the medical cases that defendant Boelling was purporting to judge as chairman of the Ad Hoc review committee.

aa. On December 8, 1982, the Board of Medical Examiners, with defendant Russell abstaining, agreed that it would take no disciplinary action against plaintiff with reference to any professional conduct on his part up to that time, and plaintiff in return agreed to dismiss his litigation against the Board over the reprimand letter dated April 21, 1980. Plaintiff thereafter dismissed that litigation but reserved his right, insofar as defendant Russell is concerned, to complete this lawsuit.

bb. Plaintiff's surgical infection rate is as good as or better than defendant Harris's surgical infection rate. Plaintiff's mortality rate is as good as or better than defendant Harris's mortality rate.

cc. Columbia Memorial Hospital's governing body is a Board of Trustees comprised of 15 persons, two of whom are physicians who are also members of the Hospital's

medical staff. Defendant Gary M. Boelling was one of the two physician-members of the Board in 1977, 1978, 1979, 1980 and 1981, until he resigned effective June 25, 1981. B. J. Henningsgaard was the other physician-member of the Board in 1977, 1978, 1979 and 1980, until his death in August, 1980. Following Dr. Henningsgaard's death, defendant Leigh Dolin completed the balance of the deceased member's 1980 term on the Board, and was a physician-member of the Board in 1981 and 1982. Following defendant Boelling's resignation, defendant Richard G. Kettelkamp completed the balance of Dr. Boelling's 1981 term, and was the other physician-member of the Board in 1982. Although neither party has information at the present time about the other 13 Board members, defendants intend to provide this information, and have agreed to the inclusion of this paragraph conditioned upon such supplementation.

In 1981 the members of the Columbia Memorial Hospital Executive Committee were defendants Kettelkamp, Dolin, Harris, Rappaport, Meyer and Drs. John Swanson and Charles K. Linehan. In 1981 the heads of all clinical service committees of the Hospital were individuals who are defendants herein.

dd. Plaintiffs deny defendants' contentions of fact.

ee. Plaintiffs adopt their contentions of law and incorporate them herein to the extent that said contentions involve mixed questions of fact and law.

6. *Contentions of Fact (cont.)*

ASTORIA CLINIC DEFENDANTS

a. The Astoria Clinic defendants deny the plaintiffs' contentions of fact.

b. Neither the activities of the plaintiffs nor the Astoria Clinic defendants involve interstate commerce.

c. The activities of the Astoria Clinic were motivated by concern for provision of high quality health care.

d. Plaintiffs failed to provide care in accordance with the standards of their profession in one or more of the following ways:

- 1) Abandonment of patients;
- 2) Failure to obtain adequate consultations prior to surgery;
- 3) Failure to diagnosis [sic] condition of patient;
- 4) Failure to possess and/or exercise the skills required in the performance of thoracic surgery;
- 5) Failure to possess and/or exercise the skills required in the performance of vascular surgery;
- 6) Being disruptive members of the staff of Columbia Memorial Hospital.

e. Plaintiffs should have been the subject of corrective action by the Columbia Memorial Hospital for one or more of the following reasons:

- 1) Failure to provide health care in accordance with the standards of the profession; and
- 2) Being disruptive members of the medical staff.

f. The Astoria Clinic defendants adopt their contentions of law and incorporate them herein to the extent that said contentions involve mixed questions of fact and law.

6. *Contentions of Fact (cont.)*

DEFENDANT COLUMBIA MEMORIAL HOSPITAL

a. Columbia Memorial denies plaintiffs' contentions of fact.

b. The activities of the defendant Hospital were proper and customary and related to its duties under law as an accredited hospital, under the Bylaws of the medical staff of the Hospital, and related to its obligations to the medical staff and the members thereof, including plaintiffs, and its obligations to its patients.

c. Any and all activities of the defendant Hospital were motivated by concern for the provision of high-quality health care.

d. Plaintiff demonstrated an inability to work with others as a member of the staff of the Hospital to the extent it jeopardized patient care.

e. Plaintiff's conduct was properly the subject of requests for corrective action in that his activities and professional conduct were properly considered to be lower than the standards and/or aims of the medical staff and/or to be disruptive to the operations of the Hospital.

f. Staff privileges at Columbia Memorial are limited to licensed physicians who:

"* * * can document their background, experience, training and demonstrated [sic] of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the medical staff and the governing body that any patient treated by them in the hospital will be given a high quality of medical care." Article III, § Bylaws, Rules and Regulations, Medical Staff, Columbia Memorial Hospital, Astoria, Oregon, revised and adopted April 24, 1975 (hereinafter "Bylaws").

Privileges are conferred only on those physicians who "continuously meet" these requirements. Bylaws, Article III, Section 1. The Bylaws establish a regular appoint-

ment and reappointment process to insure that these requirements are met.

Staff physicians whose conduct is called into question are subject to a multi-level review process.

Any staff member's conduct may become the subject of a request for "corrective action" if his "activities or professional conduct are considered to be lower than the standards or *aims* of the medical staff or to be disruptive to the operation of the hospital." (Emphasis added.) Bylaws, Article VII, Section 1.a.

g. Plaintiff failed to provide adequate and good medical care in accordance with the standards of his profession at defendant Hospital in one or more of the following ways:

- 1) Abandonment of patients;
- 2) Neglect of patients;
- 3) Failure to obtain adequate consultations prior to surgery;
- 4) Failure to diagnose conditions of patients;
- 5) Failure to possess and/or exercise the skills required in the performance of thoracic surgery;
- 6) Failure to possess or exercise the skills required in the performance of vascular surgery;
- 7) Failure to cooperate as a staff member at the Hospital with personnel, medical staff and Hospital administration;
- 8) Being a disruptive member of the staff of the Hospital;
- 9) Generally rendering substandard medical care; and

10) Failure to participate cooperatively in peer review.

h. Plaintiff breached his agreement under the Bylaws.

i. Plaintiff improperly failed and refused to abide by the peer review set out in the Bylaws.

j. Plaintiff improperly attempted to frustrate peer review as mandated by Oregon law and set out in the Bylaws.

k. Complaints to the Board of Medical Examiners and with regard to plaintiff's conduct at the Hospital and/or requesting corrective action were justified and warranted and brought about by the actions and inactions of the plaintiff.

l. The defendant Hospital never acted in the peer review process in that plaintiff resigned as a member of the staff prior to any recommendation by the ad hoc hearing committee and thus prior to any action taken by the governing body of the Hospital.

m. Plaintiff was advised, prior to the commencement of the hearing process with regard to his staff privileges, of several representative and appropriate charges of substandard medical care in repeated instances and that the charts were "representative" charts of behavior and attitude patterns. He was further advised that his substandard medical care was reflective of attitude problems on his part in that he had demonstrated an inability or unwillingness to work well with his peers, and a willingness to sacrifice his patients' interests to his own. He was further advised that his unwillingness to listen to his

peers and accept the discipline of peer review was involved in the statement of the charges for the hearing.

n. Subsequent to his resignation in April of 1982 as a member of the staff at Columbia Memorial Hospital, plaintiff later indicated his interest in again becoming a member of the medical staff. The Hospital Board of Trustees specifically instructed its Executive Director to notify Dr. Patrick that the Hospital would accept a reapplication from Dr. Patrick for staff privileges. The Board also instructed Dr. Patrick would be given the same opportunity as any licensed physician in applying for credentials and privileges. This was communicated to Dr. Patrick; however, Dr. Patrick never submitted any application to regain the privileges or credentialing at Columbia Memorial Hospital since his resignation.

o. No representative of the Hospital has ever conspired or combined in any manner to restrain competition or monopolize the practice of surgery or any other area of medicine.

p. The defendant Hospital had no part in Dr. Patrick's resignation from the medical staff at defendant Hospital, and Dr. Patrick has waived and is estopped to assert any claim with regard to staff privileges by virtue of his resignation and failure and refusal to reapply for staff privileges. The Hospital has never acted on Dr. Patrick's staff privileges, due to his resignation.

q. Defendant Hospital has suffered substantial financial losses by reason of the fact that plaintiff resigned his privileges at the Hospital.

r. Neither the activity of plaintiff or defendants involve interstate commerce.

s. The relevant geographic market includes Portland, Oregon, and Longview, Washington.

t. The defendant Hospital adopts its Contentions of Law and incorporates them herein the extent that said contentions involve mixed questions of fact and law.

u. In applying for staff privileges, plaintiff expressly acknowledged that he had read the Hospital's Bylaws and agreed to be bound by them.

7. *Contentions of Law.*

PLAINTIFFS

a. Beginning on approximately July 21, 1973, defendants have combined and conspired among themselves and with others, including Drs. McLaughlin and Stull, to restrain competition in and to monopolize the practice of surgery within the relevant market, in violation of §§ 1 and 2 of the Sherman Act and of ORS 646.725 and 646.730. The relevant geographic market is northern Clatsop County, Oregon, and the southern part of Pacific County, Washington, and the relevant lines of commerce is the practice of general, vascular and thoracic surgery. Plaintiffs' and defendants' activities in the practice of surgery within the relevant market have a substantial impact on interstate commerce. The total surgical revenue in the market area exceeds \$1,000,000. Many Washington residents use plaintiffs' and defendants' services, and account for a significant portion of that total revenue. In addition, both plaintiffs and defendants purchase significant quantities of medical supplies and equipment from out-of-state suppliers and receive income from out-of-state sources, such as Medicare, Medicaid and insurers.

b. The acts of defendants as stated in the agreed facts and contentions of fact had the purpose and effect of a restraint of trade and attempted monopolization.

c. The Hospital is the largest and best equipped facility within the relevant market. The Clinic defendants constitute a majority of physicians in Astoria. Because of the Clinic defendants' domination of the Hospital Staff and Committees, and defendants' domination of the relevant market in general, defendants' actions have a dangerous probability of success in eliminating or weakening competition from plaintiffs and monopolizing the market.

d. Plaintiffs have suffered damages in the amount of \$2,250,000 in decreased income as a result of defendants' actions. In addition, defendants' conduct harms the general public by upsetting the orderly practice of medicine in the market, by reducing the number of surgeons and the competition among them, by depriving the public of choice and of high-quality medical care, and by eliminating an independent professional voice reviewing the quality of medical care being offered in the market.

e. Plaintiffs contend that defendants' conduct not only constitutes violations of federal and state anti-trust law, but also constitutes tortious interference with plaintiffs' practice of the profession of surgery and business and professional relationships with third parties. Defendants wrongfully interfered with plaintiff's staff privileges at Columbia Memorial Hospital and forced him to resign from the staff. In addition, defendants have interfered with plaintiffs' relationships with individual patients. They have also refused to call upon plaintiffs when patients seen in the emergency room of Columbia Me-

morial Hospital indicate their preference for Dr. Patrick. Finally, they refuse to refer any prospective patients to plaintiffs. The Clinic defendants have refused to continue treating patients who requested plaintiffs' surgical services. This wrongful interference by defendants has damaged plaintiffs in the amount of \$2,250,000.

f. Furthermore, defendants' conduct is willful and malicious, and plaintiffs are entitled to punitive damages in the amount of \$4,000,000.

g. Plaintiffs deny defendants' contentions of law.

h. Plaintiffs adopt their contentions of fact, and incorporate them herein to the extent that said contentions involve mixed questions of fact and law.

7. *Contentions of Law (cont.)*

ASTORIA CLINIC DEFENDANTS

a. The Astoria Clinic defendants deny plaintiffs' contentions.

b. This Court lacks subject matter jurisdiction over the claims asserted under 15 USC §§ 1 and 2.

c. Plaintiffs' claims, if any, under ORS 646.725-730 are barred and/or waived by reason of the provisions of ORS 646.780(2).

d. Plaintiffs' claims under the provisions of ORS 646.725 and Section 1 of the Sherman Act are to be judged under the rule of reason, rather than the per se test of illegality.

e. The Astoria Clinic defendants have not engaged in any conduct that would constitute either a conspiracy

to monopolize or an attempt to monopolize any line of trade or commerce.

f. The Astoria Clinic defendants lacked the specific intent to monopolize; possessed no dangerous probability of success; and no conduct of its [sic] proximately related to competitive injury to plaintiffs.

g. Plaintiffs' claims are barred, in whole or in part, by their failure to exhaust the administrative remedies available under and pursuant to the Medical Staff Bylaws of Columbia Memorial Hospital.

h. To the extent that plaintiffs seek to claim damages with respect to matters which occurred more than four years prior to the commencement of this action, their damages are barred by the applicable statute of limitations.

i. Plaintiffs' claims are barred, in whole or in part, by the Noerr-Pennington Doctrine.

j. That plaintiffs' claims are barred, in whole or in part, by implied repeal of the antitrust laws.

k. Plaintiffs' claims are barred in whole or in part by the State Action Doctrine.

l. Plaintiffs' claims, to the extent that they relate to peer review or staff privilege review proceedings, are barred by reason of immunities granted under state law.

m. Evidence with respect to peer review and staff privilege review is inadmissible herein.

n. Evidence with respect to proceedings before the Board of Medicine Examiners is inadmissible herein.

o. Plaintiff Timothy A. Patrick lacks standing to pursue the claims herein in that he has been an employee of a corporation at all times relevant.

p. Plaintiffs lack standing to pursue any claims or damages relating to Sandy Patrick.

q. Plaintiffs' claims are barred in whole or in part herein by reason of the provisions of the Medical Staff Bylaws of Columbia Memorial Hospital.

r. Plaintiffs cannot recover under their tort claims herein in that the conduct of the Astoria Clinic defendants is privileged.

s. Plaintiffs have failed to avoid and/or mitigate their damages.

t. The conduct of the Astoria Clinic defendants do not proximately relate to damages to plaintiffs.

u. Plaintiffs' damages are speculative.

v. Plaintiffs' claims, to the extent that they relate to proceedings before the State Board of Medical Examiners, are barred by immunities granted under state law.

w. Plaintiffs may not recover under both their federal claim and state based claims.

x. The tort claims of plaintiffs are preempted by federal law.

y. The state law claims should be segregated for separate trial from the federal claim by reason of the different standards for admission of evidence.

z. Plaintiffs' tort claim for intentional interference with contractual relations or prospective advantage is barred by the statute of limitations.

aa. Plaintiffs waived or are estopped to pursue their claims pertaining to staff privileges by reason of Timothy A. Patrick's resignation from the medical staff.

bb. If they have been damaged at all, plaintiffs have not been damaged beyond the fact of any alleged interference itself with their business or patient relationships.

cc. The Astoria Clinic defendants' conduct promoted a value, the provision of quality medical care, which is equal to, or greater than, plaintiffs' competitive interests.

dd. To the extent the members of the Astoria Clinic were acting as agents of Columbia Memorial as medical staff members, the defendants constituted a single economic entity which is incapable of conspiracy.

ee. To the extent that Dr. Russell was acting as a member of BOME, he was not acting within the scope and course of any agency with the Astoria Clinic.

ff. To the extent that individual members of the Astoria Clinic were acting as agents of Columbia Memorial as medical staff members, they were not acting within the course and scope of any agency with the Astoria Clinic.

gg. Astoria Clinic's conduct was part of a process established by the Hospital to promote efficiency and quality in the provision of health care services. Plaintiffs' records of poor medical practices and interpersonal conflicts necessitated the conduct, rather than having an anticompetitive purpose or effect, was procompetitive and

promoted efficiency and quality in the delivery of health services.

7. *Contentions of Law (cont.)*

DEFENDANT COLUMBIA MEMORIAL HOSPITAL

a. Columbia Memorial Hospital ("Columbia Memorial") denies plaintiffs' contentions.

b. This Court lacks subject matter jurisdiction over the claims asserted under 15 USC §§ 1 and 2.

c. Plaintiffs' claims, if any, under ORS 646.725-730 are barred and/or waived by reason of the provisions of ORS 646.7BO(2).

d. Columbia Memorial has not engaged in any conduct that would constitute either a per se violation of the antitrust laws or an unreasonable restraint of trade.

e. Plaintiffs' claims under the provisions of ORS 646.725 and 15 USC § 1 are to be judged under the rule of reason, rather than the per se test of illegality.

f. Columbia Memorial has not engaged in any conduct that would constitute a conspiracy or attempt to monopolize.

1. Under plaintiffs' allegation, the relevant product market is "the practice of general, vascular and thoracic surgery."

2. Columbia Memorial does not compete in that product market, had no specific intent to monopolize that market, and neither succeeded nor achieved a dangerous probability of success toward monopolizing that market.

g. Columbia Memorial's conduct did not unreasonably restrain competition in the practice of general, vascular and thoracic surgery in the relevant geographic market properly defined. Competition in the relevant market properly defined has not been injured by the acts complained of by plaintiffs.

h. Columbia Memorial's conduct was part of a process established by the hospital to promote efficiency and quality in the provision of health care services. Plaintiffs' records of poor medical practices and interpersonal conflicts necessitated the conduct of which plaintiffs complain. Columbia Memorial's conduct, rather than having an anticompetitive purpose or effect, was procompetitive and promoted efficiency and quality in the delivery of health services.

i. Plaintiffs' claims are barred because they have failed to exhaust the available administrative remedies provided by the Medical Staff Bylaws and state law.

j. To the extent that plaintiffs seek damages on their antitrust claims with respect to matters which occurred more than four years prior to the commencement of this action against Columbia Memorial, these damages are barred by the applicable statute of limitations.

k. Plaintiffs' claims are barred, in whole or in part, by the Noerr-Pennington Doctrine.

l. Plaintiffs' claims are barred, in whole or in part, by implied repeal of the antitrust laws.

m. Plaintiffs' claims are barred in whole or in part by the State Action Doctrine.

n. Plaintiffs' claims, to the extent that they relate to peer review or staff privilege review proceedings, are barred by reason of immunities granted under state law and Federal common law.

o. Plaintiffs' claims, to the extent that they relate to proceedings before the State Board of Medical Examiners, are barred by immunities granted under state law.

p. Evidence concerning the staff privilege review proceedings is inadmissible by reason of state law and Federal common law.

q. Evidence with respect to proceedings before the Board of Medical Examiners is inadmissible by reason of state law and Federal common law.

r. Plaintiffs' lack standing to pursue any claims or damages relating to the alleged failure of Columbia Memorial to hire Sandy Patrick.

s. Plaintiffs' claims are barred in whole or in part by reason of the provisions of the Medical Staff Bylaws of Columbia Memorial and by reason of the waiver provision of their staff privilege application.

t. Plaintiffs' tort claim is barred because the conduct of Columbia Memorial was privileged.

u. Columbia Memorial cannot be held liable under the antitrust laws for an anticompetitive conspiracy or conduct, if any, by the Astoria Clinic or the individual defendant physicians.

1. To the extent the individual defendant physicians were acting as agents of Columbia Memorial as medical staff members, the defendants constituted a single eco-

nomie entity which is incapable of conspiracy under the antitrust laws.

2. To the extent the individual defendant physicians were not acting as agents for Columbia Memorial, Columbia Memorial is not responsible for their conduct and did not conspire with them.

v. Plaintiffs have failed to state a claim or allege that Columbia Memorial is vicariously liable for the acts of the Astoria Clinic or the individual defendants.

w. Plaintiffs' antitrust claims are barred, unless the exclusive motivation for the alleged conduct against them was anti-competitive in nature.

x. Plaintiffs' tort claim for intentional interference with contractual or business relations is barred by the statute of limitations.

y. Plaintiffs have failed to avoid and/or mitigate their damages.

z. Conduct of Columbia Memorial did not proximately or substantially cause damages to plaintiffs, among other reasons, because plaintiffs resigned their staff privileges before Columbia Memorial acted with respect to those privileges.

aa. Plaintiffs' damages are speculative.

bb. Plaintiffs' claim to punitive damages is insufficient as a matter of law.

cc. If they have been damaged at all, plaintiffs have not been damaged beyond the fact of any alleged interference itself with their business or patient relationships.

dd. Columbia Memorial's conduct promoted a value, the provision of quality medical care, which is equal to, or greater than, plaintiffs' competitive interests.

ee. Plaintiffs' tort claims are preempted by federal law.

ff. Plaintiffs' waived, or are estopped to pursue, their claims by reason of their resignation from the medical staff and their failure to reapply.

gg. By reason of their failure to participate confidentially and in good faith in the peer review process, plaintiffs waived, or are estopped from pursuing, any claims based upon the manner in which the peer review process was conducted.

hh. Columbia Memorial adopts its Contentions of Facts and incorporates them herein to the extent that said contentions involved mix questions of law and fact.

ii. Plaintiff Timothy Patrick lacks standing to pursue the claims herein in that he has been an employee of a corporation at all times relevant.

TONKON, TORP, GALEN
MARMADUKE & BOOTH

By /s/ Janet C. Neuman
Don H. Marmaduke

Of Attorneys for Plaintiffs

SCHWABE, WILLIAMSON, WYATT,
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By /s/ Thomas M. Triplett

Of Attorneys for Clinic Defendants

STOEL, RIVES, BOLEY, FRASER
& WYSE

By /s/ Guy A. Randles

HOLMES, DeFRANCQ &
SCHULTE, P.C.

By /s/ John H. Holmes

Of Attorneys for Columbia
Memorial Hospital

IT IS ORDERED that the foregoing Pretrial Order is

X Approved as lodged.

— Approved as amended by interlineation.

DATED this 26th day of November, 1984.

/s/ Edward Leavy
U.S. DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

(Caption omitted in printing)

Civil No. 81-260-LE

JUDGMENT

The jury, having returned the following verdict:

"1. Did defendant(s) combine or conspire in restraint of trade or commerce?

"ANSWER: Yes X No —

"2. If your answer to question one is 'yes', list the name(s) of defendant or defendants who combined or conspired.

Gary M. Boelling
Franklin H. Russell
Richard C. Harris

"3. Did defendant(s) attempt or conspire to monopolize:

"ANSWER: Yes X No —

"4. If your answer to question three is 'yes', list the name or names of defendant or defendants who attempted to, or conspired to monopolize.

The Astoria Clinic

"5. If your answer to question one or three is yes, what is plaintiff's damages?

\$650,000

"6. Did defendant(s) intentionally and unlawfully interfere with plaintiff's professional or business relationships?

"ANSWER: Yes X No —

"7. If your answer to question six is yes, list the name or names of defendant(s) who interfered.

Gary M. Boelling
Frank H. Russell
Richard C. Harris

"8. If your answer to question six is yes, what is the amount of plaintiff's damages? (If you have found in favor of the plaintiff on any of the antitrust claims, do not include in this figure any sum included as damages on the antitrust claim.)

\$20,000

"9. If your answer to question six is yes and you have found damages in answer to question eight, should plaintiff recover punitive damages?

ANSWER: Yes X No —

"10. If your answer to question nine is yes, list names of defendant(s) against whom plaintiff should recover punitive damages.

Gary M. Boelling
Franklin H. Russell
Richard C. Harris

"11. If your answer to nine is yes, what amount of punitive damage to you assess?

\$90,000

"Dated this 22nd day of December, 1984.

/s/ Nadine DeLay
FOREMAN"

now, therefore, it is

ORDERED AND ADJUDGED that plaintiff Timothy A. Patrick, M.D., have judgment against the defendants William M. Burget, M.D., Jorma M. Leinassar, M.D., R.G. Kettlekamp, M.D., Patrick Meyer, M.D., Gary M. Boelling, M.D., Robert D. Neikes, M.D., Franklin H. Russell, M.D., Leigh C. Dolin, M.D., Richard C. Harris, M.D., Daniel M.

Rappaport, M.D., and Tzu Sung Chiang, M.D., doing business as Astoria Clinic, and each of them, in the sum of \$1,950,000; and it is further

ORDERED AND ADJUDGED that the amount of plaintiff's attorneys' fees and costs will be adjudicated and judgment therefor will be entered herein later; and it is further

ORDERED AND ADJUDGED that plaintiff have judgment against the defendants Gary M. Boelling, M.D., Franklin H. Russell, M.D. and Richard C. Harris, M.D., and each of them, in the additional sum of \$110,000.

DATED this 7th day of January, 1985.

/s/ Edward Leavy
UNITED STATES DISTRICT JUDGE

PETITIONER'S BRIEF

(8)
No. 86-1145

Supreme Court, U.S.

FILED

NOV 27 1987

CLERK

In The
Supreme Court of the United States

October Term, 1987

— o —
TIMOTHY A. PATRICK, M.D.,

Petitioner,

v.

WILLIAM M. BURGET, M.D., JEFFREY M. LEINASSAR, AS PERSONAL REPRESENTATIVE OF JORMA M. LEINASSAR, M.D., DECEASED, R.G. KETTLEKAMP, M.D., PATRICK MEYER, M.D., GARY M. BOELLING, M.D., ROBERT D. NEIKES, M.D., FRANKLIN D. RUSSELL, M.D., LEIGH C. DOLIN, M.D., RICHARD C. HARRIS, M.D., DANIEL M. RAPPA-PORT, M.D., and TZU SUNG CHIANG, M.D., DOING BUSINESS AS ASTORIA CLINIC,

Respondents.

— o —
**On Petition for Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit**

— o —
PETITIONER'S BRIEF

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QUESTIONS PRESENTED FOR REVIEW

1. Where a statute required a private hospital to maintain procedures for review by the staff physicians of their peers, did a bad faith abuse of the peer review process for anticompetitive reasons amount to state action which is immune from the antitrust laws?

2. Where one of the respondents served on the State Board of Medical Examiners, and abused his position after disqualifying himself from acting, does the state action doctrine protect him as well as other respondents who were in conspiracy with him, when the damages arose entirely or almost entirely from actions outside his official capacity? Does the state action doctrine require that evidence of that abuse of position be kept from the jury?

LIST OF PARTIES

There are no parties not named in the caption. The respondent Jorma M. Leinassar having died, the Court of Appeals for the Ninth Circuit ordered his personal representative substituted on February 5, 1987, and the cover so reflects.

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CITATION TO OPINION BELOW

The opinion below of the Court of Appeals is *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986).

STATEMENT OF THE GROUNDS ON WHICH THE JURISDICTION OF THE COURT IS INVOKED

The judgment of the Court of Appeals was entered on September 30, 1986. The order denying the petition for rehearing was filed on November 26, 1986. The petition for certiorari was filed January 9, 1987. The statute which confers jurisdiction on this Court to review the judgment in question is 28 U.S.C. § 1254(1).

STATUTES INVOLVED IN THIS CASE

Sherman Act § 1, 15 U.S.C. § 1:

“Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal * * *.”

Sherman Act § 2, 15 U.S.C. § 2:

“Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony * * *.”

Oregon Revised Statutes § 441.055:

“(3) The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility. The governing body shall:

.

(c) Insure that procedures for granting, restricting and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and

(d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the profes-

sional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care."

Oregon Revised Statutes § 41.675(4):

"A person serving on or communicating information to any governing body or committee described in subsection (1) of this section [governing bodies or committees of a health care facility licensed under Or. Rev. Stat. Chapter 441, including medical staff committees in connection with the grant, denial, restriction or termination of clinical privileges at a health care facility] shall not be subject to an action for civil damages for affirmative actions taken or statements made in good faith."

STATEMENT OF THE CASE

Nature of the case, and course of proceedings.

Dr. Timothy Patrick brought this action for treble damages under the antitrust laws. After a three-week trial, the jury returned a unanimous verdict in his favor. The jury found in effect that defendants deprived Dr. Patrick of hospital privileges in the course of a conspiracy or attempt to monopolize the practice of surgery in the relevant market. The District Court entered judgment in his favor for \$1,950,000, plus attorney fees. On appeal, the Court of Appeals for the Ninth Circuit reversed, holding that the state action doctrine immunized defendants' conduct.

Statement of facts.

Although the opinion of the Court of Appeals is adverse to Dr. Patrick, it does state accurately all the necessary facts. The Court of Appeals characterized the evidence against defendants as follows:

"There was substantial evidence that the defendants acted in bad faith in the hospital's peer review process and in the [State of Oregon Board of Medical Examiners] proceedings. * * * There is no doubt that the evidence, viewed in the light most favorable to

Patrick, reveals shabby, unprincipled and unprofessional conduct on the part of the defendants." Appendix to the Petition for Certiorari, 12a, 17a.

We agree. The statement of facts which follows is entirely consistent with the opinion of the Court of Appeals, but is much more detailed.

1. Astoria, Oregon.

Astoria is a town of about 10,000 people. (Tr. 2186.) It lies in the far northwest corner of Oregon, where the Columbia River flows into the Pacific Ocean. Established as a fur trading post in 1810 by John Jacob Astor, it claims to be the oldest American settlement west of the Mississippi River. A bridge across the Columbia connects Astoria to southwest Washington.

2. The practice of medicine in Astoria.

There is only one hospital in Astoria, Columbia Memorial Hospital ("CMH" or "Hospital"), with 65 beds and 20 to 25 doctors on the staff. (Tr. 156, 182, 1271; J.A. 16.) It serves the Oregon county in which it sits and the southern part of Pacific County, Washington. (J.A. 16.)

Hospitals are generally classified as primary, secondary, and tertiary, in increasing order of sophistication. (Tr. 361-62, 1271-72.) In surgery, CMH is a secondary hospital, ranking between a simple primary hospital with limited facilities and a sophisticated tertiary hospital which can do anything. (Tr. 361-62, 1271.) There is no other secondary hospital in the area for 50 miles. (Tr. 362, 418.) There is, however, a small primary care hospital 18 miles away across the Columbia in Ilwaco, Washington, but it is not equipped for surgery as complex as at CMH. (Tr. 221-23, 423 *et seq.*; Ex. 152D rec'd at Tr. 221.) The nearest tertiary hospital is in Portland, 90 miles away. (Tr. 362.)

Most of the physicians in Astoria belong to a single clinic—defendants' Astoria Clinic.¹ (Tr. 106; Ex. 134

¹At trial, both sides used the term "Astoria Clinic" as a shorthand term for defendants, who are partners in the Astoria Clinic.

rec'd at Tr. 109.) Astoria Clinic physicians have always constituted about a two-thirds majority of the medical staff at CMH. (Tr. 156-57, 182, 184.) They are a majority of the CMH Executive Committee. (Tr. 185, 2448.)

Two other physicians whose specialties do not compete with the Astoria Clinic have close ties to it, receive referrals from it, and support it in voting on staff issues. (Tr. 184-85; J.A. 17.) These are Dr. Stull, a urologist, and Dr. McLaughlin, and they were alleged in the complaint to be co-conspirators with the Astoria Clinic. (*Id.*; J.A. 4.) By and large, the Astoria Clinic doctors and their allies have controlled all of the Hospital service committees. (Tr. 185, 2448-49.) There is a Board of Trustees at the top, but as a practical matter, it is the staff that runs the Hospital, at least on medical matters, for the trustees have never opposed the recommendations of the staff. (Tr. 182, 186, 406, 1363.)

3. *Dr. Patrick comes to Astoria.*

Dr. Patrick is a 46-year old surgeon. (Tr. 170.) When still a child he decided upon a career in medicine. (Tr. 171.) After Princeton came medical school at Baylor, then one year as doctor on an icebreaker, then four years as a surgical resident at Baylor and the University of Texas. (Tr. 170-71, 173, 375.) His training was in general surgery and vascular (blood vessel) surgery. (Tr. 171.) Among the vascular surgeons he trained with were the celebrated heart surgeons Drs. DeBakey and Cooley. (Tr. 171.)

In 1971, the Astoria Clinic needed a new surgeon, and invited Dr. Patrick to Astoria. (Ex. 1, 2 rec'd at Tr. 187, 188.) Dr. Patrick signed a one-year employment contract with the Astoria Clinic beginning July 1972. (Ex. 3 rec'd at Tr. 139.) He commenced practicing surgery at CMH. (Tr. 180.) In his first year he earned \$150,000 in fees for the Astoria Clinic, which paid him a salary of \$33,000. (Tr. 151-52, 385.)

4. *Dr. Patrick goes into competition with the Astoria Clinic.*

After the one-year contract was up, the Astoria Clinic offered Dr. Patrick a partnership. (Tr. 179.) He asked for a 50% share of the fees he would bring in. (Tr. 385.) The Clinic refused. (Tr. 387.) He reviewed the Astoria Clinic's finances and discovered that the overhead was extremely high. (Tr. 179.)

Although Dr. Patrick had originally intended to practice with the Astoria Clinic for the rest of his life, he declined the offer of partnership. (Tr. 173, 180.) His family wanted to stay in Astoria, so he decided to open an independent practice in general, vascular and thoracic surgery. (Tr. 180, 192.) No one had ever left the Astoria Clinic and done that before. (Tr. 192, 1168.)

5. *The Astoria Clinic resents Dr. Patrick's competing practice.*

There was resentment at the Astoria Clinic that Dr. Patrick had set up a competing practice. (Tr. 138, 1140-41.) He found their physicians had become extremely cold to him. (Tr. 192, 193.) They generally refused to refer their patients who needed surgery to him. (Tr. 193, 389-90, 679-80.) For almost a year after he declined their partnership offer, he was the only general surgeon in town. (Tr. 193.) Yet even then the Astoria Clinic doctors would usually send their patients out of town for surgery, or would simply not have them operated on. (Tr. 193.) Several years later, during another interval when the Astoria Clinic had no surgeon, they posted a notice on the emergency room at the Hospital to send surgical emergencies to Longview, 50 miles away. (Tr. 679.)²

²In argument to the jury, defendants justified their policy. (Tr. 2769.) Their counsel explained that if a Ford dealer didn't have the car which a customer wanted to buy, that dealer still would not send the customer to a rival dealer. This was a candid acknowledgment that what was going on was economic competition.

After Dr. Patrick, three other surgeons came in succession to the Astoria Clinic to practice. (Tr. 141-42, 1139.) Like Dr. Patrick, they would later leave, at least partly for economic reasons. (Tr. 141-42, 1139.) Like Dr. Patrick, they tended to be the Astoria Clinic's top earners of fees, for surgery is one of the most lucrative specialties. (Tr. 141, 144, 149, 152, 153, 1138.) For example, Dr. Harris, the last one to leave, brought in twice the income of most of the others, but the Astoria Clinic's compensation system did not reward the surgeons proportionately and they would be dissatisfied. (Tr. 143-45, 149, 152-53.) Unlike Dr. Patrick, however, none of them would stay in Astoria to open an independent practice. (J.A. 18.) For after Dr. Patrick went into competition, the Astoria Clinic would require each new doctor to sign a covenant not to compete. (Tr. 139-40, 154-55; Ex. 158 rec'd at Tr. 139.) If a doctor left the Astoria Clinic, he could not practice within the county for 16 months. (*Id.*)

6. Dr. Patrick thrives.

Notwithstanding the hostility of the Astoria Clinic, Dr. Patrick's surgical practice in Astoria grew steadily and thrived (Tr. 219.) He let it be known that he was always on call. (Tr. 212, 685.) Various witnesses testified he always responded when requested. (Tr. 1110, 1590, 1952.) Over the next 12 years, he would perform from 2,000 to 2,500 surgeries, 80% of them major. (Tr. 302, 401.) In 1975, he moved into his own office building, right across the street from the new Hospital building. (Tr. 219.) By 1981, his annual surgical fees would reach \$357,000. (Ex. 85 rec'd at Tr. 2001.)

Dr. Patrick became board-certified as a general surgeon in 1977, and was then elected to the American College of Surgeons. (Tr. 229, 402, 403.) He is a Fellow of the Society of Abdominal Surgeons, the Michael E. DeBakey International Cardiovascular Society, and the Clinical Society of Vascular Surgeons. (J.A. 16-17.)

He also took on major professional responsibilities. He served on the Executive Committee of the Oregon

Medical Association for two years. (Tr. 225-26; J.A. 17.) He was appointed to the Board of Oregon Physicians' Service from 1975 to 1981. (Tr. 228.) He was a clinical instructor at the University of Oregon Medical School. (J.A. 17.)

Dr. Patrick was eager to change things at CMH which he felt were inadequate. (Tr. 615-16.) CMH had no intensive care unit, and he became the driving force in getting one. (Tr. 178, 187, 616, 2309; Ex. 165 rec'd at Tr. 186.) He found the Hospital deficient in running IVs (intravenous fluids) and in other techniques, and spent a lot of time trying to encourage training. (Tr. 178-79.)

Dr. Patrick was the first surgeon in the area to practice vascular surgery. (Tr. 174, 175, 1470-71.) One operating room nurse testified that when he came to town it was a whole new ballgame as far as surgery was concerned. (Tr. 1967.) His relationship with his patients, she said, was just excellent. (Tr. 1970.)

One witness was a certified physician's assistant, who had assisted in thousands of surgeries in the Army and in other hospitals. (Tr. 1096 *et seq.*, 1101, 1102.) In Astoria, he assisted practically all the surgeons. (Tr. 1101, 1107, 1111.) He testified that Dr. Patrick was an extremely committed surgeon, never refusing to see a patient day or night, and that he handled unexpected contingencies in a very orderly fashion. (Tr. 1108-10.) For his own surgery, he would choose Dr. Patrick without hesitation. (Tr. 1110.) Of the surgeons with whom he had operated, he wouldn't put anyone else above him. (Tr. 1115.)

Dr. Foster, the first orthopedist in town and one of the few physicians who was independent of the Astoria Clinic, testified that Dr. Patrick was certainly a better surgeon than Dr. Harris, who was the Astoria Clinic's surgeon when Dr. Patrick lost his privileges at CMH. (Tr. 860.)

Dr. Patrick also performed major surgery at the small Ocean Beach hospital across the Columbia in Ilwaco,

Washington. (Tr. 402, 673.) The Chief of Staff of that hospital, Dr. Neace, assisted Patrick in surgery and testified that he was "excellent." (Tr. 1589, 1592, 1601.) He told the jury that Dr. Patrick was very dedicated, always responded very rapidly and never refused to assist when asked. (Tr. 1589, 1590.) He said Dr. Patrick had no problems getting along with the doctors there. (Tr. 1590.)

Dr. Campiche, another Ocean Beach doctor, assisted Dr. Patrick in surgery for 14 years. (Tr. 1949.) Dr. Patrick was, he testified, a natural surgeon with a very broad understanding of the complexities. (Tr. 1951.) Even after defendants forced Dr. Patrick off the CMH staff for alleged inadequacies, it was Dr. Patrick who Dr. Campiche chose to perform abdominal surgery on his own son. (Tr. 1963.)

7. Dr. Patrick encounters various difficulties with Astoria Clinic physicians.

The attitude of the Astoria Clinic physicians to Dr. Patrick, however, would occasionally surface in tense incidents. One patient told the jury what happened when her regular physician at the Astoria Clinic, Dr. Leinassar, wanted her to use the Clinic surgeon. (Tr. 71 *et seq.*) She preferred Dr. Patrick, said she was very satisfied with him, didn't want Dr. Harris. (Tr. 73.) She testified that Dr. Leinassar replied: "In that case I can no longer take care of you. Goodbye." (Tr. 75.) When she asked him to have her records sent to Dr. Patrick, he refused and said he could not help her further. (Tr. 75.) She had to make her own arrangements about the records. (Tr. 72.) She said she became hurt and angry, emotionally very upset. (Tr. 73.)

Dr. Foster, the independent orthopedist, remembered several incidents in which patients were sent for surgery to someone other than an Astoria Clinic physician, for reasons of competence, and a Clinic physician would vigorously object. (Tr. 852-56, 874-76.)

Dr. Patrick also encountered difficulties in seeing patients who had asked for him at CMH. Most of the CMH Emergency Room coverage was by Astoria Clinic doctors. (Tr. 215, 451.) From time to time Dr. Patrick would learn of one incident or another, usually through a coincidence.

When one patient arrived in the Emergency Room with her injured son, she asked for Dr. Patrick. (Tr. 90-93.) She was told he was unavailable, and so another doctor started treatment. (Tr. 90-93.) She was shocked to encounter Dr. Patrick himself a few minutes later there in the hospital. (Tr. 90-93.)

Another patient twice came to the emergency room in need of a surgeon, and asked for Dr. Patrick. (Tr. 79, *et seq.*) The emergency room doctor the first time was the defendant Russell, and she didn't remember who was there the second time. (Tr. 79, *et seq.*) Each time she was immediately told that Dr. Patrick was out of town, on vacation, unavailable, which wasn't true. (*Id.*; Tr. 196.) In both cases she saw Dr. Patrick in the Hospital the day after her surgery. (Tr. 80-81, 83.)

After an auto accident, another woman brought her 6-year-old grandson to the emergency room where she found the defendant Russell, among others. (Tr. 85, *et seq.*) The child was hysterical, and the grandmother asked for Dr. Patrick, who had treated the child previously. (*Id.*; Tr. 203-04.) She testified that when she kept asking for Dr. Patrick she was shunned, and wondered, "What's wrong here?" (Tr. 87.) No one at the Hospital called Dr. Patrick. (Tr. 87-89.) Later the child's parents did so, and he went directly to their home to attend to the child. (Tr. 88.)

Later, as Dr. Patrick's suspicions grew, he started keeping records at the request of his attorney. (Tr. 211-12.) He discovered, in a short period in early 1981, six patients who had been admitted into the emergency room without notifying him. (Tr. 202-12.) In each case the patients had listed Dr. Patrick or his new associate (whose

hiring is discussed later) on the Hospital form as their doctor. (*Id.*) For example, the defendant Dr. Rappaport, the Astoria Clinic pediatrician, admitted one of them—an elderly woman—then continued to care for her for days without ever notifying Patrick. (Tr. 206-07; Ex. 90 rec'd at Tr. 197-99.)

8. *Dr. Patrick finds it impossible to obtain cross-coverage.*

Dr. Patrick had to leave Astoria at least occasionally. For one thing, he had to meet an annual requirement for continuing medical education, not all of which could be done locally. (Tr. 227, 408-10.) For another, there were board meetings of the Oregon Medical Association and other medical organizations in which he held office. (Tr. 193.)

Ten months after Patrick had turned down the Astoria Clinic's offer of partnership, the Clinic obtained a new surgeon, Dr. Marik. (Tr. 193.) At that point it would have been customary for Dr. Patrick and the Astoria Clinic surgeon to work out an agreement whereby when one was absent, the other would look after his patients in the Hospital. (Tr. 2207-08.) Dr. Patrick did approach Dr. Marik with that suggestion, for their mutual benefit and for their patients' benefit. (Tr. 193.) The Astoria Clinic partners, however, vetoed the suggestion, saying that Patrick was not an Astoria Clinic surgeon and therefore could not be allowed to care for Astoria Clinic patients. (Tr. 194.) Dr. Patrick renewed his suggestion to the defendant Dr. Harris, who became the Astoria Clinic surgeon four years later, and was again rebuffed. (Tr. 194, 233-34, 1677-78.) The defendant Dr. Dolin admitted that there was no other surgical coverage available to Dr. Patrick if he couldn't get it from the Astoria Clinic surgeon. (Tr. 2501, *cf.* Tr. 423, 671-72.) An Astoria Clinic official explained that having no backup was what happened to someone who went independent. (Tr. 153.) Coverage from outside Astoria was impractical. (Tr. 423, 670-72.)

Although the Astoria Clinic physicians saw to it that Dr. Patrick could not have cross-coverage by another surgeon, they also attacked him when he didn't get it. (Tr. 351-52.) For example, on one occasion when Dr. Patrick went to a meeting in Portland, he left a patient in the care of one of the independent doctors, a family practitioner. (Tr. 234-35.) The defendant Dr. Boelling of the Astoria Clinic thereupon made a written complaint. (Tr. 484 *et seq.*) Other incidents occurred, which will be discussed later.

9. *Dr. Patrick is treated unequally in peer review at the hospital.*

The term "peer review" often appears in this and other medical cases. It seems that the term is used for two different but related processes. One use of the term is the discussion by the staff of the treatment of particular cases as they arise in the hospital. This process is required by the Joint Commission for Accreditation of Hospitals, and its purpose is educational—constructive criticism of the conduct of a particular case. (Tr. 439-40, 674.)

The other use of the term is the more serious formal hospital disciplinary process by which a physician's hospital privileges are limited or revoked. In the CMH by-laws which govern the staff, it was known as "Corrective Action." (Ex. 156 p. 9, rec'd at Tr. 304.)

All complications after surgery were supposed to be reviewed. (Tr. 290-91, 676-77, 881-82.) Complications include infections, anything that was not to be normally expected. (Tr. 290-91, 676-77, 881-82, 944.) All complications were supposed to be listed in the patient's discharge summary. (Tr. 289-90, 676, 944, 1383.) If they were, they would automatically be flagged by Medical Records for peer review. (Tr. 290, 1238-39.) If a surgeon omitted mention of infections and other complications from his discharge summary, he would thereby escape peer review by the Surgery Committee. (Tr. 289-91, 1238-39, 1680.) Failing to report them therefore skews the entire peer review process. (Tr. 676, 1788.)

Dr. Patrick reported his infections, and listed his complications. (Tr. 290-91.) One of the Astoria Clinic's witnesses against Dr. Patrick at trial conceded that his chart documentation was well done, that he made no attempt to obscure any findings. (Tr. 2148.)

This was not the case, however, with the Astoria Clinic's surgeon.

In 1978 the Astoria Clinic hired a new surgeon, the defendant Dr. Harris. (Tr. 233.) Dr. Patrick became aware that Dr. Harris in particular was not reporting his complications. (Tr. 442, 675-76, 882, 1681.) Dr. Foster said that he knew, from his observation of isolation signs on the doors of Dr. Harris' patients, that his patients were having a lot of infections which weren't being reported. (Tr. 944-45, 952-53.) Dr. Foster reported this to Dr. Patrick, who was then Chief of Surgery. (Tr. 953.)

At trial, it developed that Dr. Harris' infection rates were indeed much higher than Dr. Patrick's. (Tr. 1324-28; Ex. 184 rec'd at Tr. 1324-26.) Dr. Harris claimed that he forgot to mention complications. (Tr. 675, 1681.) If he had listed his infections on the discharge summary, they would have been reviewed by the Surgery Committee and dealt with. (Tr. 1790-92.)

In December 1978, Dr. Patrick operated on the cancerous lung of a certain patient. (Tr. 235 *et seq.*, 493 *et seq.*) He asked Dr. Harris to come give an appraisal, and to help. (Tr. 236.) Dr. Harris and his partner Dr. Boelling used the occasion to attack Dr. Patrick's surgical privileges. (Tr. 1767.) Dr. Patrick decided to use the occasion to try to develop a better working rapport with Dr. Harris. (Tr. 240, 1882.) Dr. Harris was board-certified in thoracic surgery, and Dr. Patrick wasn't. (Tr. 176, 236.) Therefore Dr. Patrick, who was still Chief of Surgery, himself suggested that he undergo a six-month probationary period in thoracic surgery, and requested that Dr. Harris be appointed his proctor. (Tr. 240-41, 1704.) Dr. Patrick co-

operated with the probation, at the end of which Dr. Harris found no fault with any of his thoracic cases, and the probation ended. (Tr. 240 *et seq.*, 1704, 1819, 1883-84.) On one of these cases, Dr. Harris himself worked with Dr. Patrick, and admitted he had no criticism of it. (Tr. 1705.) Later, however, it would be one of the cases which defendants would claim to rely in revoking Dr. Patrick's privileges at CMH. (Tr. 243, 306; Ex. 106, 113 rec'd at Tr. 306, 307.) Dr. Harris would testify later that he did have criticisms of Dr. Patrick during this probation, but that he didn't tell Dr. Patrick about them. (Tr. 1705-07.)

Dr. Harris replaced Dr. Patrick as Chief of Surgery. (Tr. 1786.) When he did, the peer review system in the Surgery Committee gradually broke down. (Tr. 286, 882.) Dr. Foster testified that under Dr. Harris it did not work fairly or uniformly, that Dr. Harris tended not to bring up his own complications or Dr. McLaughlin's, but would discuss Dr. Patrick's frequently. (Tr. 882-83.) There was evidence that Dr. Stull covered up for a surgical mistake by Dr. Harris. (Tr. 1314, 1315, 1316, 1701, 1702.) Dr. Harris routed his own cases for peer review to Dr. Stull or to other Astoria Clinic doctors, and admitted he did not route them to Dr. Patrick to review. (Tr. 286, 675, 1317, 1703.) He routed Dr. Patrick's cases for review to Dr. Stull, or to other Astoria Clinic doctors. (Tr. 286, 675.)

The case of Dr. McLaughlin, an alleged co-conspirator with defendants, is instructive of the different standards at CMH for discipline. Dr. McLaughlin, an orthopedist, was brought to town in 1977 by Dr. Foster, who was independent of the Astoria Clinic. (Tr. 842.) Dr. Foster explained to the jury that he had to fire Dr. McLaughlin the next year on account of his unresolvable mental problems. (Tr. 8433, 1865-66.) Dr. Marik, who was then the Astoria Clinic surgeon and CMH Chief of Surgery, told Dr. Foster that his employee Dr. McLaughlin had suffered a nervous breakdown in the operating room and aborted a simple

operation, that he was mentally incompetent, and should not be allowed to operate alone. (Tr. 939-41.) Dr. McLaughlin confirmed the story to Dr. Foster. (Tr. 941.) Although defendants reported Dr. Patrick to the state Board of Medical Examiners on various occasions, they did not report this matter of Dr. McLaughlin. (Tr. 941.)

Dr. Foster therefore fired Dr. McLaughlin based on what the Astoria Clinic surgeon had told him. (Tr. 941.) The Astoria Clinic then invited Dr. McLaughlin to join—"informally"—in Dr. McLaughlin's words. (Tr. 1851, 1862.) He rented seven rooms at the Astoria Clinic and began receiving the Astoria Clinic's orthopedic referrals. (Tr. 117-19, 845-46, 1853, 1856.)

The mental instability to which Dr. Foster testified also surfaced in an incident directed against Dr. Patrick. The Hospital Maintenance Supervisor testified that one day as he stood in a hospital hallway talking to Dr. Patrick, Dr. McLaughlin approached from behind, unseen by Dr. Patrick, and knocked Patrick with his shoulder into Shepard and the wall. (Tr. 1461-62.) Shepard reported this incident, as required, but nothing was done. (Tr. 1256, 1262, 1281.)

An alcoholic, Dr. McLaughlin admitted to being drunk in the emergency room. (Tr. 1869-70.) None of these incidents, nor his alcoholism, were ever the subject of any peer review or discipline within the Hospital. (Tr. 941, 1872, 1874.) None were ever reported to the Board of Medical Examiners until years later when he himself applied for a state impaired-physicians program. (Tr. 1871.)

Dr. McLaughlin was made Chief of Staff of the Hospital from September 1978 through December 1979. (Tr. 1805.)

10. Dr. Patrick hires an associate.

The Astoria Clinic's refusal to allow cross-coverage for Dr. Patrick, and its attacks on him for not having it, caught him in a trap; feeling increasing pressure from the Astoria Clinic-oriented Hospital committees, he decided the

only way to protect himself was to hire another surgeon. (Tr. 195.) In July, 1979, his new surgeon-employee, Dr. Weber, arrived in Astoria. (Tr. 245, 420, 1406-07.) At that point the Astoria Clinic still had two-thirds of the doctors in town, but Patrick had two-thirds of the surgeons, one of the most profitable specialties. Tr. 245, 1138, 1141-42.) That had never happened before. (Tr. 1142.) Also, just the previous year the Astoria Clinic had built a new and larger office building, the defendants becoming personally obligated on a \$1.5 million loan. (Tr. 128-29, 132-33.) Their overhead had increased substantially, their rent rising from \$6,000 to \$16,000 per month. (Tr. 132-33.)

Within weeks of Dr. Weber's arrival, the Astoria Clinic doctors began attacking him aggressively. (Tr. 245.)

On October 5, the independent orthopedist Dr. Foster was caring for an elderly patient. (Tr. 856 *et seq.*, 1132 *et seq.*) He found the woman's leg had no blood at all. (Tr. 856, 1411.) This was an emergency, requiring the fastest treatment possible. (Tr. 856-57, 1411.) He summoned Dr. Weber immediately from the operating room, who then with the patient's permission removed a clot from the artery, and saved the leg. (Tr. 856-57, 1136, 1411.) The defendant Dr. Burget, however, found out about it in the meantime from the nursing supervisor. (Tr. 1133.) He headed for the x-ray suite where he found Dr. Weber about to perform the arteriogram, and told him in front of the patient that she was an Astoria Clinic patient and that Dr. Weber should not be taking care of her. (Tr. 1134, 1411.) Dr. Burget was aware that it was an urgent situation and that the leg could be lost, but he wanted his partner Dr. Harris to do the surgery instead. (Tr. 1134-36.) Dr. Weber observed: "This was essentially my first introduction to Astoria medical politics." (Tr. 1411.)

Two weeks later, Dr. Weber saw a patient in the Emergency Room. (Tr. 1412 *et seq.*; Ex. 25 rec'd at Tr. 2000-01.) The patient asked Dr. Weber to continue to treat him, even though he had formerly been treated by the defendant Dr.

Neikes. (*Id.*) The patient explained this to Dr. Neikes. (*Id.*) Dr. Neikes was quite angry, upset the patient, and filed a complaint against Dr. Weber. (*Id.*)

11. *The disparate treatment of the Willie case and the Unander-Scharin case.*

A few days later, one Leroy Willie was injured in an auto accident. (Tr. 246 *et seq.*) His case was to mark an escalation of this conflict.

Dr. Patrick performed emergency surgery on Mr. Willie. (*Id.*) Because he then had a medical meeting 2½ hours away, he asked his employee Dr. Weber to cover for him. (Tr. 247-48, 547.) Dr. Weber was due to leave Sunday morning for a College of Surgeons meeting in Chicago, and Dr. Patrick was due back Sunday afternoon, unless notified by Dr. Weber that he was needed earlier. (Tr. 548, 1416.) Dr. Weber saw the patient early Sunday morning, decided there was no need to recall Dr. Patrick, and carried out their plan to have Dr. Linehan, an independent family practitioner, cover for the estimated six-hour interval until Dr. Patrick returned. (Tr. 247-48, 1416.) With the problems they had encountered from the Astoria Clinic, Dr. Weber did not try to arrange for coverage by Dr. Harris. (Tr. 1418, 1430.)

That morning, the nurses called Dr. Linehan for help with the patient, who was in respiratory distress. (Tr. 247, 249, 548.) Dr. Linehan asked for help from the defendant Dr. Boelling, who was the Director of Respiratory Therapy at the Hospital. (Tr. 251, 1171.) Dr. Boelling refused to help the patient because he was a patient of Dr. Patrick's. (Tr. 1172.)

The Chief of Staff — Dr. McLaughlin — then transferred the patient's care entirely to Dr. Harris. (Tr. 250, 1895.) Dr. Harris would later decide to make an unnecessary transfer of the patient by ambulance to Seattle, 200 miles away—Portland being only 90 miles away—long after Dr. Patrick had returned to Astoria. (Tr. 251, 549, 1897; Ex. 38 rec'd at Tr. 1024, Ex. 173 rec'd at Tr. 1030-32.) En

route to Seattle, the ambulance's respiratory equipment malfunctioned, and the patient eventually died. (*Id.*)

At about the same time, Dr. Harris operated on a 15-year old boy, Peter Unander-Scharin, recently injured in a motorcycle accident. (Tr. 252 *et seq.*, 850-52.) Dr. Foster, the orthopedist in attendance, noticed that the boy was getting sicker, and told Dr. Harris that he had an abdominal injury. (Tr. 851.) Dr. Harris overruled him, and for five days failed to recognize that the child had ruptured his small intestine, before operating to fix it. (Tr. 252, 687-88, 851.) He then left town to go to Chicago at a time when the boy was having very high temperature spikes, leaving him in the care of an internist and a urologist. (*Id.*; Ex. 29 rec'd at Tr. 253.) He also left behind him two other seriously ill surgical patients on whom he had recently operated. (*Id.*)

Dr. Foster became steadily more concerned that something was still gravely wrong with the boy. (Tr. 852.) He tried to get a surgeon to see the boy, but defendant Dr. Boelling resisted. (Tr. 852.) He resisted, Dr. Foster testified, because the remaining surgeon in town was Dr. Patrick, and he wasn't a member of the Astoria Clinic. (Tr. 852.) The discussion became heated. (Tr. 852.) The boy, Dr. Foster said, was dying. (Tr. 852.) Dr. Foster finally prevailed and was able to get Dr. Patrick to see the patient. (Tr. 852.) Dr. Patrick operated, found a large abscess, and the boy lived. (Tr. 255-56, 852.)

Although no action was taken against Dr. Harris, the CMH Executive Committee, a majority of whom were Dr. Harris' partners together with Dr. McLaughlin, voted to report Dr. Patrick and Dr. Weber to the state Board of Medical Examiners. (Tr. 947, 1912; Ex. 1130 rec'd at Tr. 2001.)

12. *The irregular proceedings before the Board of Medical Examiners.*

The defendant Dr. Russell, a partner in the Astoria Clinic, had become Chairman of the Investigative Commit-

tee of the Board of Medical Examiners only a few months earlier. (Tr. 712; J.A. 18.) It was to his Committee that the complaint against Dr. Patrick came. (Tr. 260.) One of the other two doctors on his Committee, Dr. Larson, was the neurologist to whom the Astoria Clinic referred many of its patients. (Tr. 123, 260-61, 706, 712-13.)

Dr. Patrick and Dr. Weber were summoned to appear before Dr. Russell's Investigative Committee on January 2, 1980. (Tr. 260 *et seq.*, 550, 744.) When Dr. Patrick arrived, Dr. Russell announced on the record that he would not participate in the proceedings due to a conflict of interest between his group and Dr. Patrick's. (Tr. 261, 744-45.) The case of Leroy Willie was discussed and Dr. Patrick explained the circumstances. (Tr. 261-62.) No other case was discussed or even mentioned. (Tr. 262, 733, 1026-27.) When Dr. Patrick appeared before the full Board eight days later, they all went over the Willie case again. (Tr. 261-62, 551.) While Patrick was in the presence of the full Board, Dr. Russell again announced a conflict of interest and removed himself from the discussion. (Ex. 38 rec'd at Tr. 1024.)

It was only in litigation much later, after discovery which was fiercely resisted, that Dr. Patrick discovered what happened after he left. (Tr. 683-84.) It is true that Dr. Russell did keep silent after he had announced his conflict of interest—but only for so long as Dr. Patrick was present. (Tr. 746-47; Ex. 38 rec'd at Tr. 1024.) The minutes revealed that before Dr. Patrick arrived, and as soon as he left, Dr. Russell took part vigorously and critically. (*Id.*) It was Dr. Russell who would make the Investigative Committee's report to the full Board. (*Id.*; Tr. 747.) When Dr. Patrick was not present, Dr. Russell told the Board what the facts supposedly were, based on his own personal knowledge in Astoria, severely criticizing Dr. Patrick. (*Id.*) Dr. Russell also exonerated his partner, Dr. Boelling, for refusing to help Willie while he was in respiratory distress, and gave the Board incorrect information

about his partner's role. (*Id.*; Tr. 728-29, 733, 1171-72; Ex. 26 rec'd at Tr. 1171-72.)

Four months later, the Board of Medical Examiners issued a public letter of reprimand to Drs. Patrick and Weber. (Ex. 51 rec'd at Tr. 262-63.) The letter was sent to the Chairman of the Board of the Hospital, to the Chief of Staff, and to the Administrator. (*Id.*; Tr. 752.) It was published throughout the Hospital and discussed among the staff. (Tr. 1448.) Again in litigation much later it was discovered that it was Dr. Russell who wrote the letter, although it came out over the signature of Dr. Tanaka, the Chairman of the Board. (*Id.*; Tr. 717, 1028-30; Ex. 48 rec'd at Tr. 1028-29, 1093-94, 2001-02; Ex. 50 rec'd at Tr. 1028.) Dr. Tanaka did not know about Dr. Russell's conflict of interest, for he had not attended the Board meeting at which Dr. Patrick had appeared, due to a blizzard. (Tr. 961-63, 1020.) He agreed to the letter based on what was told him, and signed on behalf of the Board, not knowing that Dr. Russell had drafted it. (Tr. 962-63, 966-67.)³

The letter was harshly critical of Drs. Patrick and Weber in six areas. (Ex. 51 rec'd at Tr. 262-63.) The first was criticism of the Willie case, for having left the patient without coverage by another surgeon. (*Id.*) Dr. Patrick wrote to the Board that he accepted this criticism as fair. (Tr. 268, 551-52; Ex. 54 rec'd at Tr. 268.) It was

³The Board also sent another letter to the Hospital. (Ex. 1189 rec'd at Tr. 553, 964.) There appeared in this letter the only words in either letter which Dr. Tanaka wrote himself. He said:

"* * * it appears to the Board that there is an atmosphere of animosity, professional jealousy and contentiousness within the medical community in Astoria that exceeds the parameters of healthy competition, so that seeking consultation, getting 'curbstone' opinions and coverage during inevitable periods of absence can be awkward, embarrassing and at times frankly impossible." (*Id.*; Tr. 964-65.)

This was followed, however, by a statement that the Hospital could rely on Dr. Russell to "interpret the intent of the Board." (*Id.*) There was some evidence that it was Dr. Russell who added that sentence. (Tr. 997.)

to prevent just such occurrences that he had hired Dr. Weber, although his plans had gone awry in this particular case. (Tr. 251.)

What appalled Dr. Patrick about this letter, which he didn't know Dr. Russell had written, was its severe criticism of him in five other areas which had nothing to do with the Willie case, the only one he was told was under consideration. (Ex. 51 rec'd at Tr. 268.) Yet the letter recited that the Board had reviewed the charts of 14 of his other patients, and interviewed witnesses. (*Id.*) He protested because he was being publicly rebuked for his treatment of 14 patients whose names he had never been told, about whose treatment he had never been given a chance to present his side, all on the basis of evidence given in secret by those unidentified "several witnesses" whom he had never been given a chance to confront. (*Id.*; Ex. 54 rec'd at Tr. 268.) Although defendants would later argue that he was technically reprimanded only for the Willie case, all one has to do to know that it was a public reprimand for much more than that is to read it. (Ex. 51 rec'd at Tr. 262-63.)

Dr. Patrick asked the Board who the other 14 patients were, and asked for an opportunity to present his side. (Ex. 54 rec'd at Tr. 268.) Dr. Tanaka, the Chairman of the Board, thought his request was fair. (Tr. 971.) At Dr. Tanaka's insistence, and after some delay, the Board did eventually tell Dr. Patrick the names of the 14 patients. (Tr. 270 *et seq.*, 971-73; Ex. 55 rec'd at Tr. 270.) When Dr. Patrick learned their names, he felt the criticism about these 14 was unjustified: he asked for either a modification of the reprimand, limiting it to the Willie case, or a fair hearing to give him a chance to respond to the accusations about the other cases. (Tr. 272-74; Ex. 61 rec'd at Tr. 272.)

In secret session, Dr. Russell argued against Dr. Patrick's request, saying the Board had no further obligation. (Tr. 722-23, 972-73.) Dr. Tanaka nevertheless responded by offering to meet with Dr. Patrick to discuss

the cases in detail, and Dr. Patrick agreed. (Tr. 274, 973.) Dr. Tanaka was accompanied by Dr. Battalia, one of the two independent consultants whom the Board had asked to review the 14 charts. (Tr. 274, 973.) The three went over the cases in detail. (Tr. 274, 555.) Dr. Tanaka concluded that the letter of reprimand was an overstatement and should be modified. (Tr. 275, 974-75; Ex. 170 rec'd at Tr. 1017.)

Dr. Tanaka would later appear voluntarily, without subpoena, as a witness at trial for Dr. Patrick in this case. (Tr. 1022.) He testified that he reported back to the Board of Medical Examiners about the excessive statements in the reprimand letter. (Tr. 974.) Dr. Tanaka explained to the jury some of the cases. (Tr. 975 *et seq.*) For example, one of them was a patient brought to the emergency room already virtually dead from a gunshot wound. (Tr. 976-77.) The criticism (in this case, of Dr. Weber) was for taking heroic measures to try to save him, trying to do more than was justified under the circumstances.⁴ Another of Dr. Patrick's 14 cases he described as a rare condition—a "hepatic aneurysm"—which he said he had fortunately never encountered himself:

"I think most surgeons would call it a nightmare situation. You have a patient that is going to die on you if you don't do something quick, and you don't really know what has to be done." (Tr. 976.)

In yet another of the 14, the criticism had been that Dr. Patrick had not called in an internist, and the record showed that in fact he had done so. (Tr. 978.)

Dr. Patrick therefore expected the Board to issue a modification of the letter, but it refused. (Tr. 276, 557.) What happened was that Dr. Russell, again in secret and unknown to Dr. Patrick until discovery much later, argued against it. (Tr. 723, 975; Ex. 170 rec'd at Tr. 1017.) He opposed letting Dr. Patrick have a hearing because then

⁴In Dr. Tanaka's singularly infelicitous phrase, Dr. Weber was only guilty of "overkill." (Tr. 977.)

Dr. Patrick would know who had complained to the Board about him, i.e., mainly Dr. Russell's partners, Drs. Boelling and Harris, and the co-conspirators Drs. McLaughlin and Stull. (Tr. 760, 763, 1034, 2542-43.) As for modifying the reprimand, Dr. Russell said that the matter was now final, closed as far as he was concerned and should not be reopened. (Tr. 724, 763.) However, a few months later, his partner Dr. Harris would cite the existence of the Board's investigation as a reason to recommend revocation of Dr. Patrick's privileges at CMH. (Ex. 82 rec'd at Tr. 1781.) And it would be Dr. Russell himself, in his role as a member of the CMH Executive Committee, who would then make the motion to that effect, which motion carried, eventually resulting in the demise of Dr. Patrick's practice. (Ex. 1292 p. 14 rec'd at Tr. 729-30.)

As for the letter itself, Dr. Patrick filed suit against the Board for violation of his due process rights and for violation of the Oregon Administrative Procedure Act. (Tr. 557-58; Ex. 149 rec'd at Tr. 277-78.) The Board then withdrew the reprimand letter in its entirety. (Tr. 278, 982; Ex. 114 rec'd at Tr. 278.)

There was one other aspect of the reprimand letter which bears a closer look. In the course of the investigation, the Board had asked two independent consultants to review the 14 patient charts. The only one of them who expressed an opinion—Dr. Battalia—sided with Dr. Patrick on a number of the issues even before meeting with him. (Ex. 173 rec'd at Tr. 1031-32.) On some issues Dr. Battalia wrote that those who were criticizing Dr. Patrick didn't understand the situation and could use a refresher course. (*Id.*) He wrote that Dr. Harris' decision to transfer Willie to Seattle was "a stupid move," with Portland so much closer. (*Id.*) Dr. Russell saw to it that none of this surfaced in the public letter to Dr. Patrick.

We now draw the Court's attention to one of the more significant discrepancies between Dr. Battalia's letter and

Dr. Russell's letter which was purportedly based upon it:

Battalia's letter

"It is of interest to note that all three surgeons [Patrick, Weber and Harris] in the Astoria area qualify themselves as general and thoracic surgeons. Since there are only three surgeons in town, I question that their expertise in the field of thoracic and cardiovascular surgery is as high as those making this a separate specialty and since this specialty is available, again, more frequent and earlier transfer [e.g. to Portland] would be to the betterment of the patient involved." (Ex. 173 rec'd at Tr. 1031-32.)

Russell's letter

"6. Surgery. Both surgical consultants questioned the wide variety of surgery and how you [Patrick and Weber] could maintain efficiency with so few of each, notably vascular and chest cases * * * This is an area that needs careful scrutiny by you both." (Ex. 51 rec'd at Tr. 262-63.)

We draw the Court's attention to several aspects of this comparison of the two letters. First, and least important, Dr. Russell misrepresented that two consultants had expressed such an opinion, when in fact only one had. (Ex. 174 rec'd at Tr. 1031-32.) Second, and more important, the criticism by the one consultant who did have an opinion was directed equally at all three Astoria surgeons, including Dr. Harris—Dr. Russell's partner. Note, however, how Dr. Russell made it appear that the criticism is directed only against Dr. Patrick and his associate. Third, bear in mind that what is being discussed is thoracic and vascular surgery, the most lucrative branch of the most lucrative specialty in Astoria. (Tr. 224, 1138.) Fourth, where the consultant recommends that all three—including Dr. Harris—should perhaps ship more of this lucrative work out of Astoria, Dr. Russell omits this sug-

gestion entirely and suggests only that his partner's competitors Drs. Patrick and Weber should stop doing it.

Soon after Dr. Russell's letter came out over Dr. Tanaka's signature, his partner, Dr. Harris, formally requested to the CMH Executive Committee that Dr. Patrick's privileges in thoracic surgery cease. (Tr. 281-82, 1774; Ex. 56 rec'd at Tr. 282.) Why did he do so then, when almost a year had passed since Dr. Patrick completed his voluntary probation in thoracic surgery under Dr. Harris without criticism? Dr. Harris explained why—it was because of Dr. Russell's letter:

" * * * I recall in the letter that came back from the State Board that, among other things, [it] had recommended curtailing thoracic and vascular privileges; and I felt at that time that after thinking this over, that we were obligated to do something as Chief of Surgery." (Tr. 1785.)

Nothing came of this effort at the time, however, because defendants attempted to draw the Oregon Medical Association into the process, and it did not respond. (Tr. 282-83, 2493-94, 2502-03; Ex. 78 rec'd at Tr. 283.)

13. *The Snodgrass case.*

In November 1980, Dr. Patrick made a surgical mistake, which he admitted. (Tr. 342-43.) He operated on a boy, Stuart Snodgrass, who had been referred to him by another doctor with a diagnosis of appendicitis. (Tr. 342, 560.) A few days later he operated again, thinking the boy was suffering an abscess from the first surgery. (Tr. 344.) He called for a urological consultation, which disclosed that the boy had testicular cancer. (Tr. 344-45.) Dr. Patrick's error was in failing to do a complete physical, relying unjustifiably on the exam performed by the referring physician. (Tr. 347, 562.)

14. *The move to revoke all Dr. Patrick's privileges at CMH.*

On January 24, 1981, Dr. Harris wrote a letter demanding "corrective action" against Dr. Patrick under

the hospital bylaws. (Ex. 82 rec'd at Tr. 1781.) His grounds, in addition to the Snodgrass case, were:

—Dr. Patrick's thoracic probation under Dr. Harris two years before, in which Dr. Harris had expressed no criticism to Dr. Patrick.

—The proposed OMA review of Dr. Patrick's thoracic cases which Dr. Harris himself had initiated and which had done nothing.

—The Board of Medical Examiners' investigation.

—Another medical case, the Partridge case, about which there was a great deal of evidence at trial, with conflicting views, but about which the County Medical Society had concluded after some criticism in peer review (Ex. 70 rec'd at Tr. 294) that Dr. Patrick's care of the patient "was not felt to be unethical or incompetent," and "did not [emphasis in original] document any ongoing pattern of inappropriate care." (Ex. 82 rec'd at Tr. 1781.)

In the CMH Executive Committee, Dr. Russell moved to revoke Dr. Patrick's privileges at the Hospital. (Ex. 1292 p. 14 rec'd at Tr. 729-30.) His partner, Dr. Dolin, seconded the motion. (*Id.*; Tr. 730-31.) Six of the eight members present were Astoria Clinic doctors. (Ex. 1292 p. 1 rec'd at Tr. 729-30.) The motion to revoke carried. (*Id.*)

Dr. Patrick requested a hearing as allowed by the bylaws. (Ex. 87 rec'd at Tr. 297.) In response, the Executive Committee issued a notice of charges in which it declared that it had relied on the letter of reprimand from the Board of Medical Examiners, among other things. (*Id.*)

This notice also identified 21 of his patient charts upon which the Committee said it relied to revoke his privileges. (*Id.*; Ex. 88 rec'd at Tr. 300.) There were several curious aspects about this. *First*, it wasn't true, since the only case which the minutes and the verbatim transcript show was discussed by the Committee was the Snodgrass case. (Ex. 1292 rec'd at Tr. 729-30.) Indeed, the origin of those 21 cases would remain a perpetual

mystery: no one who was involved would ever admit to remembering where they came from or who put the list together. (Tr. 303, 1246, 1248, 1354-55, 1711-12, 1737, 2241.) The notice, however, had been drawn up in the boardroom of the Astoria Clinic itself. (Tr. 1246 *et seq.*, 1736, 2240-41.) *Second*, three of the cases on which the Executive Committee said it relied in revoking Dr. Patrick's privileges were not even his patients. (Tr. 299-301.) *Third*, one of the patients was the one on whom Dr. Harris had worked together with Dr. Patrick as part of his voluntary thoracic probation, and about which Dr. Harris registered no complaint. (Tr. 243, 302, 506, 1705.)

Most of these cases would eventually be dropped, leading to a hearing on Dr. Patrick's treatment of nine patients out of the 2,000 to 2,500 surgeries he had done in his career. (Tr. 301-02.) As for most of these remaining nine, there was no evidence that they had ever been the subject of peer review at the Hospital. They spanned a nine-year period, from 1972 through 1981. (Tr. 301.) Two were from his first year in practice at the Astoric Clinic, after which he had been offered a partnership. (Tr. 303, 1159.)

Neither were these nine typical of his average cases. (Tr. 302.) Dr. Warrington, an experienced board-certified general surgeon, testified that they did not warrant revocation. (Tr. 766 *et seq.*, 771.) He explained that they included very rare, unusual and tragic circumstances which could happen to any surgeon. (Tr. 771 *et seq.*) The Snodgrass case, he said, was an oversight, but it was a "very, very rare complication" for a cancerous testicle to masquerade as acute appendicitis. (Tr. 786-87.) About the nine in general, he said that "only Christ himself" would be immune. (Tr. 787.)

The defendants called two experts against Dr. Patrick at trial. (Tr. 2080 *et seq.*, 2246 *et seq.*) Neither testified that his privileges should have been revoked. (*Id.*) One conceded that anyone raking over his own career could find

a dozen debatable cases of his own. (Tr. 2296-97.) The other refused to answer a similar question, saying he was not the one on trial. (Tr. 2137.)

15. *The hearing panel is appointed.*

When the ad hoc committee was formed upon Dr. Patrick's request for a hearing, he objected to various members of the panel as biased. (Tr. 582-86.) He also made a proposal through his counsel:

"We suggest that all parties, including the Hospital, will best be served by having the controversy concerning Dr. Patrick's Hospital privileges decided by one or more physicians from outside Astoria, who have no prior connection with this controversy, and who are to be appointed by a professional medical organization, such as the Oregon Chapter of the American College of Surgeons or the Oregon Medical Association. Dr. Patrick is willing to agree to abide by the recommendations of a truly impartial investigation. We suggest this approach will resolve the controversy in a way which will prove to be more professional, less disruptive, less public, and less expensive, than any other approach." (Ex. 91 rec'd at Tr. 1739-40.)

A few months later, he renewed his proposal. (Ex. 107 rec'd at Tr. 1739-40.) It was denied.⁵ (Tr. 311.)

Dr. Patrick therefore faced a panel of five Astoria physicians, only one of whom was independent of the Astoria Clinic. Dr. Chiang was a partner and a defendant in this action which by then had already been filed. (Tr. 123-24, 584.) Dr. Stryker had previously been a partner in the Clinic for years, retained close economic and personal ties to the Astoria Clinic, and was receiving payments from them. (Tr. 125-28, 165, 311-12, 585, 905, 906, 908, 913, 921; J.A. 18.) Dr. Devine had all of the Astoria Clinic's radiology business and was receiving about \$4,000

⁵Much later, on the eve of trial, the Hospital settled with Dr. Patrick for the sum of \$100,000.

a month from the Astoria Clinic. (Tr. 110 *et seq.*, 587, 1165.)

The Chairman of the hearing committee was the defendant Dr. Boelling himself. (Tr. 125, 1153.) It was Dr. Boelling who had been Chief of Respiratory Therapy and had refused to help the patient Willie when in respiratory distress, because he was Dr. Patrick's patient. Dr. Patrick had criticized Dr. Boelling in that case for allowing medical politics to hurt a patient, but it was Dr. Boelling who would now sit as judge of the dispute (Tr. 1172-73; Ex. 38 p 11 rec'd at Tr. 1024.) It was Dr. Boelling who had unsuccessfully fought Dr. Foster to keep Dr. Patrick from treating the dying patient his partner Dr. Harris had left.

Of the nine cases with respect to which Dr. Boelling was now to sit in judgment of Dr. Patrick, he had criticized Dr. Patrick in secret to the Board of Medical Examiners about three of them, in addition to the Willie case, and in some of them he had been personally involved. (Tr. 1156-59, 1179, 1205, 1741-42.) As for these three, which were included in the list supposedly relied upon by the Executive Committee to revoke Dr. Patrick's privileges, the consultant to the Board of Medical Examiners, Dr. Battalia, had previously disposed of Dr. Boelling's secret criticisms as follows:

- Otto Bode: "I do not understand why this case is up for review. A straightforward performance [sic] with rapid and proper care."
- Inez Nygren: "I do not feel this is a justified complaint." (name miswritten as "Inez Cannon," *cf.* Tr. 772.)
- Roy Kemmer: "The choice of the procedure in this situation was correct in spite of the fact of a very high mortality. Doing nothing would have carried a 100% mortality. I find no criticism in this

case." (name miswritten "Kamer.") (Ex. 173 rec'd at Tr. 1031-32.)

16. *The hearings are biased.*

The hearings commenced. Dr. Stryker showed complete disinterest. (Tr. 352-53.) He focused all of his attention on tying fishing lures, reading medical journals and filling out his patient charts. (Tr. 353, 907.) Dr. Boelling, the Chairman, read his medical journals, did miscellaneous items, and read *Time* magazine. (Tr. 353.) Dr. Devine paid attention to his radiologic journals rather than to Dr. Patrick's presentation. (Tr. 353, 2223.) The defendant Dr. Chiang read journals or did chart work. (Tr. 353.) The independent, Dr. Browning, was the most attentive. (Tr. 353.)

The court reporter at this hearing testified that there was a lot of attention given to the prosecution side, but not much given to Dr. Patrick's defense. (Tr. 1492.) He testified that there was a lot of chit-chat among the panel when Dr. Patrick's attorney was presenting his case or cross-examining. (Tr. 1492.) He confirmed the tying of fishing lures and the working on charts, and testified that Dr. Devine was repeatedly irritated and wanted to get the whole thing over with. (Tr. 1492, 1494.)

There came a point when Dr. Patrick's attorney asked the members of the panel to testify about the cases which were within their personal knowledge. (Tr. 355.) They refused. (Tr. 355.) Dr. Patrick's attorney also asked each of them to testify about their possible bias, and about whether they had prejudged the case. (Tr. 356.) Each refused. (Tr. 356.)

17. *Dr. Patrick resigns.*

At this point it was obvious to Dr. Patrick that it was hopeless to expect a fair hearing, and he felt that revocation was a foregone conclusion. (Tr. 356-57.) By this time he had also discovered the fact of Dr. Boelling's prior secret testimony on three of the nine cases. (Tr. 1205.)

Dr. Patrick felt that to have his privileges revoked in such a hearing would keep him from being a surgeon anywhere, forever. (Tr. 357.) At a new hospital one must answer whether one's privileges have ever been revoked, and it is extremely difficult to be accepted if they have. (Tr. 357.) It would also be almost impossible to obtain malpractice insurance. (Tr. 357-58.) He therefore resigned from the staff on April 8, 1982. (Tr. 592, 607.)

In order to salvage as much as he could, Dr. Patrick sought and obtained full privileges at the smaller Ocean Beach Hospital where he had long had courtesy privileges. (Tr. 358, 359, 1598.) However, surgery at Ocean Beach could not replace what he had lost at CMH, since it did not have facilities to perform vascular surgery, his most lucrative specialty. (Tr. 224, 360, 366-67.) Indeed, he is losing his proficiency in vascular surgery. (Tr. 368-69.) He now does five to eight surgeries a month, compared with the 20 to 25 he used to do. (Tr. 366.) His practice and his reputation have suffered in various other ways. (Tr. 368.) Defendants do not challenge his evidence of actual damages.

SUMMARY OF ARGUMENT

The Court of Appeals misunderstood the state action doctrine. The state of Oregon has never authorized conduct such as defendants' conduct in this case. Indeed, Oregon explicitly provides by statute that defendants have immunity for their actions in peer review only if they act in good faith. As the Court of Appeals found, these defendants acted in bad faith. If the state declares that they shall be liable for bad faith, there is no conflict with federal antitrust law which also declares that they shall be liable. The state action doctrine serves only to resolve conflicts between federal antitrust law and state policy. When there is no conflict between the two, it has no logical function.

The State of Oregon does require hospitals to conduct peer review. It does not follow, however, that the state thereby intended to displace competition with regulation. The express purpose of the state policy is only to improve patient care. To require hospitals to examine the qualifications and performance of the physicians on its staff does not reduce competition among those physicians. If anything, it increases it.

Neither is there any active supervision by the State of Oregon of peer review. This peer review occurred in a private hospital. There is no state agency which oversees what happened. There is no state agency to which Dr. Patrick could appeal the decision below.

As for Dr. Russell's actions at the Board of Medical Examiners, there is no state action exemption. He disqualified himself at the outset from participating. Under Oregon law he thereafter had no authority at all to act further on behalf of the state. Furthermore, his duplicitous and surreptitious actions were a sham, and the state action doctrine should not protect sham behavior.

Whether or not Dr. Russell's actions at the Board of Medical Examiners amounted to state action, the judgment against these defendants was on account of the loss of Dr. Patrick's hospital privileges. It was not the Board which deprived him of his privileges, and the relevance of the evidence of what happened at the Board is only to show more of the detail and scope of the conspiracy. For that reason, the evidence was admissible, whether or not the conduct itself was protected by the state action doctrine.

ARGUMENT

A. The jury found that defendants specifically intended to monopolize the practice of surgery in the relevant market.

The relevant line of commerce in this case is the practice of surgery. (J.A. 33.) A hospital is an essential facility to the practice of surgery. The relevant geographic

market is part of two counties in Oregon and Washington. (J.A. 33.) In this geographic market there is only one hospital of the necessary type. Defendants have deprived Dr. Patrick of access to that essential facility. They have effectively destroyed their most significant competition in the practice of surgery. He therefore brought this action against them for attempting or conspiring to monopolize the practice of surgery in the relevant market, in violation of Section 2 of the Sherman Act.⁶

Defendants argued, however, that what they did to Dr. Patrick was professionally justified and was motivated by a belief that he was an inadequate surgeon. Judge Leavy therefore instructed the jury that if that were true, it would be a complete defense:

“ * * * If you find that the defendant—that a defendant’s conduct was predominantly motivated by legitimate business or professional aims and not by a specific intent to injure or destroy competition, you must find in favor of the defendant on plaintiff’s conspiracy and attempt to monopolize claim. * * * ”

“You’re instructed that if defendants’ practices were motivated by concerns over provision of health care to the community and are of the type which would govern reasonable persons confronted with the same or similar circumstances, then you should find that the defendant did not have the specific intent to monopolize the market for surgical services.” (Tr. 2922-23.)

The jury therefore necessarily disbelieved defendants and found that they were motivated by a specific intent to monopolize. And as the Court of Appeals said, there is no doubt that there was substantial evidence to support that verdict. Nevertheless, the Court of Appeals held that whatever defendants did, even in bad faith, was immune under the state action doctrine.

⁶There was also a Section 1 claim and a state law claim. The verdict on these claims found only Drs. Harris, Russell, and Boelling liable. (J.A. 45-46.)

B. The state action doctrine only protects conduct which a state clearly authorizes and actively supervises.

The state action doctrine emerged in this Court’s decision in *Parker v. Brown*, 317 U.S. 341 (1943). California had imposed controls on raisin growers and prohibited competition in price and marketing. *Id.* This Court rejected an antitrust challenge to the California scheme, holding that Congress did not intend for the Sherman Act to prohibit states from imposing restraints on competition in order to regulate it. This Court said that the Sherman Act was directed against individual and not state action.

This Court elaborated upon the state action doctrine in several cases which followed. In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), it articulated the test which is now used to ascertain whether a particular anticompetitive practice is justified by the state action doctrine:

“First, the challenged restraint must be ‘one clearly articulated and affirmatively expressed as state policy’; second, the policy must be ‘actively supervised’ by the State itself.” *Id.* at 105.

The Court of Appeals misapplied this test.

C. What defendants did in peer review is not protected by the state action doctrine.

1. The State of Oregon did not clearly articulate and affirmatively express a state policy that physicians shall use the peer review process in bad faith to exclude their competitors.

Was the restraint which Dr. Patrick challenged one which was clearly articulated and affirmatively expressed as state policy? The Court of Appeals declared that it was, observing that Oregon law does require peer review, does require hospitals to organize their medical staff so as to review professional practices and to make decisions about hospital privileges. Or. Rev. Stat. § 441.055.⁷ Second, the Court of Appeals infers from this statute an in-

⁷As we pointed out in footnote one to our petition for certiorari, at least 36 states have similar statutes.

tent to replace competition with regulation, and an intent that it shall be competitors who regulate each other. The Court of Appeals therefore finds that whatever is done in the guise of peer review has been authorized by the state.

This is bad reasoning, bad policy, and worse law.

Consider first what the state of Oregon itself has said about its policy. The state has said that the reason for requiring peer review is to improve patient care, and to reduce morbidity and mortality. Or. Rev. Stat. § 441.055 (3)(d). The state has not said that the reason for requiring peer review is to restrict competition among physicians. The two things are not the same, and one does not necessarily flow from the other.

The Court of Appeals, however, reasoned that they were the same, that peer review of physicians by physicians necessarily is equivalent to a restraint on competition. It said:

"An analogous scheme would allow General Motors, Chrysler and Ford to review the safety of Toyotas to determine if the public should be allowed to drive them." Appendix to Petition 12a.

The first thing wrong with this reasoning is that it ignores the structure of the market. There are physicians, and there are hospitals, and they operate in different lines of commerce. Hospitals do not generally compete with physicians, and physicians do not generally compete with hospitals. The statute which requires peer review is a statute which tells hospitals what to do. It in effect requires hospitals to use care in contracting to allow physicians on their staffs, just as another statute might require hospitals to use care in purchasing food or medicine. A statute which required hospitals to be careful about their purchases of food or medicine would hardly be considered a statute which replaces competition with regulation. If anything, it would be seen as sharpening the competition among purveyors to hospitals.

It should be no different with peer review. The only distinction in peer review is that the hospital's decisions about which physicians it will accept are made by other physicians. That is necessary, presumably because hardly anyone else would have the expertise to make those decisions. But when they make them, they do so on behalf of the hospital, as agents of the governing body of the hospital. See Or. Rev. Stat. § 441.055(3). So long as they fulfill their professional and fiduciary duty, so long as they act in the best interests of the hospital in making decisions about hospital privileges, their actions are actions of the hospital, rather than actions of competitors. It is only when they act as if no duty exists, only when they make privilege decisions based on their own private interests, that they act as competitors regulating each other.⁸

The Court of Appeals also made an unconscious and unjustified assumption about the effect of peer review. It assumed that mandatory peer review restricts competition among physicians for access to hospitals. It assumes that if it were not for peer review, more physicians would have more privileges in more hospitals. There is nothing in the record to support that assumption. Even if no statute required peer review, a hospital would still have to make decisions when physicians apply for staff privileges. There is no reason to suppose a hospital would accept every physician who applied. In the absence of statutorily required peer review, a hospital's decisions on such applications might be governed by anticompetitive motives of influential members of its staff. The effect of the statute is to require that those decisions be made instead in accordance with the purposes stated in the statute: "reducing morbidity and mortality and for the improvement of patient care." Or. Rev. Stat. § 441.055(3)(d).

⁸Bear in mind also that the statute does not require that the physicians who make privilege decisions be in competition with those about whom the decisions are made. A physician is not necessarily in competition with every other physician.

As one District Court observed:

"An examination of the [Pennsylvania] regulatory scheme does not reveal an intention to replace competition in the market for hospital medical staff positions among physicians with a regulatory structure. The [Pennsylvania] regulations provide that the denial of medical staff privileges may only be based on professional or ethical grounds, which could be viewed as procompetitive, since it prohibits denials made for purely anticompetitive reasons." *Posner v. Lankenau Hospital*, 645 F. Supp. 1102, 1117 (E.D. Pa. 1986).

And as another District Court observed:

"Indeed, the peer review process is arguably procompetitive, for by monitoring the qualifications and performance of physicians it may compensate for the relative lack of information about these matters by consumers." *Quinn v. Kent General Hospital*, 617 F. Supp. 1226, 1239 (D. Del. 1985)⁹

See also Havighurst, *Doctors & Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1128-31 (1984).

The irony in the Court of Appeals' opinion is that it produces an effect exactly the opposite of what the state expressly intended. When peer review is abused for anticompetitive purposes, it will lead to worse care, not to better. Those physicians who are good can compete by being good. Those who are not as good cannot compete as well. If they are more powerful, however, and unprincipled, the Court of Appeals has made it easier for them to use their power to subvert the peer review process and

⁹Both District Court opinions expressly rejected the contrary reasoning of *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985), on which the Court of Appeals relied in this case. *Marrese* may perhaps be distinguishable on its facts from the present case by the plaintiff's inability there to suggest bias arising outside the peer review process itself, but its reasoning is still flawed.

destroy their better competitors. More than one witness in this case testified that Dr. Patrick was a better surgeon than the Clinic surgeon. If that is so, then the quality of patient care in Astoria has become worse, not better.

There is one other statute which demonstrates that state policy does not countenance what happened in this case. Oregon law provides that those who participate in peer review are immune from liability for damages—if they act in good faith. Or. Rev. Stat. § 41.675(4). They are not immune if they act in bad faith. The Court of Appeals said that these defendants acted in bad faith. Yet it says they are immune, and that it is Oregon law which immunizes them. This does not follow.

One should bear in mind that the reason for the state action doctrine is "to resolve conflicts that may arise between principles of federalism and the goal of the antitrust laws." *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 61 (1985). But where is the threat to federalism? Oregon presumes that the physicians who take part in peer review will do so professionally, in good faith: the practice of medicine is still a noble profession, even if it may now also be a line of commerce. Oregon's policy is to shield those physicians who act professionally, in good faith, and to abandon to their fate those who do not. If the State of Oregon chooses to disown the actions of those who act in bad faith, what principle of federalism compels the Court of Appeals to ignore that choice? It may be difficult in some state action cases to draw a line between conflicting state and federal policies. However, when the state itself has drawn a line which excludes any conflict, why reject that solution?

To do so runs counter to all the principles which this Court has announced for resolving conflicts with the antitrust laws. Antitrust immunity is disfavored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system. *National Gerimedical Hospital v. Blue Cross of Kansas City*,

452 U.S. 378, 388 (1981). This Court has rejected the state action defense in various cases where it was not sufficient to clear that the state approved or required the conduct in question. *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). It has never before been presented with a state action defense in which the state disapproves of the conduct in question.

2. The State of Oregon does not actively supervise peer review.

Even if what defendants did was pursuant to a clearly articulated state policy, their defense still fails to satisfy the second prong of the state action doctrine. The state does not actively supervise peer review. The ways in which the Court of Appeals professed to find that it did are insufficient.

a. There is no supervision by the Board of Medical Examiners.

The Court of Appeals held:

"When a health care facility terminates or restricts the privileges of a physician, it must promptly report to the [Board of Medical Examiners] all facts and circumstances that caused the termination or restraint. Or. Rev. Stat. § 441.820(1). Supervision by the Board, a state agency, is equivalent to supervision by the state." Appendix to the Petition 10a.

There is a tremendous leap between the first and second sentences. The receipt of information about what has happened is not equivalent to active supervision of what has happened. The Board of Medical Examiners has no authority at all over hospitals and their decisions on privileges. There is no appeal to the Board, and it cannot compel a hospital to change its decision. It had no power or influence over the hospital proceedings in this case. All it does is receive information reported to it, presumably to know whether it should do something about the physician's license to practice medicine, a matter that is within

its jurisdiction. Consider, by comparison, that all drivers of automobiles in Oregon must also promptly report changes of address to the Motor Vehicles Division, Or. Rev. Stat. § 807.560, but that does not mean that the Motor Vehicles Division is engaged in active supervision of changes in dwelling by the populace.

b. The possible availability of state law remedies in tort or contract is no evidence of active state supervision.

The Court of Appeals also stated:

"The hospital's decisions terminating or restricting privileges are also judicially reviewable. Oregon courts have reviewed adverse privilege decisions to determine if they were made in good faith pursuant to fair procedures and were supported by the facts. See *Straube v. Emanuel Lutheran Charity Board*, 287 Or. 375, 600 P.2d 381, 386-87 (1979), *cert. denied*, 445 U.S. 966 (1980); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398, 1401 (1975)." Appendix to Petition 10a-11a.

There are two things wrong with this analysis. First, in both the cases on which the Court of Appeals relies, the Oregon Supreme Court expressly refused to hold that a disappointed peer review participant had any right of redress in the courts at all. Instead, the Oregon Supreme Court considered it to be an "interesting question" as to whether there was such review, a question which it said "we have assumed, (but not decided.)" *Straube*, 287 Or. at 383, 600 P.2d at 386; *Huffaker*, 273 Or. at 275, 540 P.2d at 1399.

Second, and more important, if any right of redress existed, it was only a private right in tort or for breach of contract. *Straube*, *Huffaker*, *supra*. That the State of Oregon may hold its courts open to private suits is not to say that the State of Oregon actively supervises whatever led to those suits. The state courts, for example, are open to litigants to bring actions for defamation and breach of contract, but that does not mean the state actively supervises defaming and breaching of contracts. Many states also provide state law remedies similar to the Sherman Act

for conspiracies in restraint of trade and attempts to monopolize, but the existence of such remedies at state law does not mean that the conduct which they prohibit therefore amounts to state action and is thereby immune under federal law.

c. The procedure by which hospitals are licensed does not constitute active supervision of peer review.

The Court of Appeals also notes that hospitals are licensed by the State—although not by the Board of Medical Examiners—and that

“To maintain licenses, health care facilities regularly must review privilege termination and restriction procedures to assure their conformity to applicable law. Or. Rev. Stat. § 441.030, 441.055(3)(c).”
(Appendix to Petition 11a.)

The state Health Division does license hospitals, and it does have the power to suspend a license for a variety of reasons, including the one to which the Court of Appeals referred. But all that the Health Division can do is to require hospitals to have procedures, and to review those procedures. The governing body of this hospital did have such procedures in its bylaws, and there is nothing particularly wrong with them. Ex. 156 p. 9, rec'd at Tr. 304.) There is nothing more for the Health Division to do if the hospital regularly reviews its procedures. The statutes do not provide any right of appeal to the Health Division, nor do they provide for the Health Division to supervise actively or even review a termination of hospital privileges.

It is true that the Health Division has authority over a hospital's license. It was also true, however, that the California Department of Alcoholic Beverage Control had authority over the license of any California wine dealer. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). Indeed, the state agency had the power to revoke the license of any dealer selling below the established price. *Id.*, 445 U.S. at 100. This Court

nevertheless held that that was not enough to constitute active supervision. There is no reason why it should be here.

D. What Dr. Russell did was not protected by any principle of law.

The second question presented for review addresses the question of Dr. Russell's role. Dr. Russell was the defendant who was also a member of the Board of Medical Examiners.

1. The evidence of what happened in connection with the Board of Medical Examiners was admissible.

The Board of Medical Examiners is an agency of the State of Oregon. What the Board did to Dr. Patrick was to issue a letter of reprimand. That action, however, was completely revoked by the Board before Dr. Patrick lost his hospital privileges.

The jury was instructed that Dr. Patrick could recover antitrust damages only for injury to his business or property. (Tr. 2927.) Dr. Patrick's evidence was that his income continued to climb after the letter from the Board of Medical Examiners, but that it began to fall after the vote to revoke his privileges. (Tr. 1519-20, 1530 *et seq.*)

It was for the loss of his hospital privileges, the effective loss of his surgery practice, that he recovered damages from these defendants.¹⁰ It was not the Board of Medical Examiners which took away his hospital privileges. It was these defendants.

¹⁰The only evidence of any damage relating to the Board of Medical Examiners proceeding was Dr. Patrick's testimony that he had paid approximately \$75,000 in legal fees in connection with that proceeding (Tr. 371-72, 2751.) and the peer review proceeding. It is therefore conceivable that the jury may have included that sum in its award of actual damages in the amount of \$650,000. If this Court were to reject all our other arguments with respect to the Board of Medical Examiners proceeding, the maximum relief to which defendants would be entitled would be a remittitur of the fees in connection with the Board proceeding, trebled. Fed. R. Civ. P. 59; 6A Moore's Federal Practice ¶ 59.08[7] (2d ed. 1987).

The significance to this case of what happened in connection with the Board is evidentiary. It is part of a larger whole, necessary to explain the entire story. We therefore argued to the Court of Appeals that there was no error in admitting the evidence with respect to the proceedings before the Board. (Appellee's Brief in the Court of Appeals, p. 82.)

The Solicitor General has taken the position in his Brief as Amicus Curiae that the Court of Appeals has not ruled on the propriety of this evidence. With respect, we think it did. The Court of Appeals held:

"Dr. Russell's activities as a member of the [Board of Medical Examiners] are also exempt from antitrust liability under the state action doctrine. . . .

" . . .

"Because much of the evidence presented in this case related to actions exempt under the state action doctrine, we reverse the judgment on the antitrust claims and remand to the district court to determine if Patrick has actionable antitrust claims remaining based on conduct other than the peer review process." Appendix to Petition, 12a, 14a.

The Court of Appeals said it reversed because of the admission of evidence of actions which were exempt under the state action doctrine. It said that Dr. Russell's activities were exempt. Therefore, it appears to us that the Court of Appeals has held that evidence of his activities should not have been admitted.

Assuming Dr. Russell's activities were exempt, that does not mean the jury couldn't know about them. The evidence of his duplicity and abuse of his position is admissible as background information to show a course of conduct and the purpose and character of the conspiracy. This Court has previously held in an antitrust case that it was permissible to introduce evidence of conduct even during the period that it was exempt by statute from liability in order to show a continuing combination both

before and after the exempt period. *Federal Trade Commission v. Cement Institute*, 333 U.S. 683, 704 (1948).

2. What Dr. Russell did is not even exempt under the state action doctrine.

Under Oregon law, whenever a member of the Board of Medical Examiners disqualifies himself from participating, as Dr. Russell did, he is without authority to act further. *Campbell v. Board of Medical Examiners*, 16 Or. App. 381, 394-95, 518 P.2d 1042, 1048-49 (1974); see *Creel v. Shadley*, 266 Or. 494, 497, 513 P.2d 755, 756 (1973); *Boughan v. Board of Engineering Examiners*, 46 Or. App. 287, 291, 611 P.2d 670, 672 (1980). If he had no authority from the state to act, what he did cannot be state action.

Even apart from Russell's own lack of authority, the Board of Medical Examiners had no authority to publicly chastise Dr. Patrick for his treatment of patients with respect to which it failed to give him notice and an opportunity to be heard. Or. Rev. Stat. § 183.413 *et seq.*; *Wisconsin v. Constantineau*, 400 U.S. 433, 437 (1971); (Ex. 149 rec'd at Tr. 277-78.) The Court of Appeals for the Fifth Circuit rejected the state action defense in refusing to dismiss a claim against the Executive Director of the Florida Board of Medical Examiners who was alleged to have abused his position. The action he had taken against another physician was not authorized, at least not without appropriate procedure, and was apparently for personal motives. *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 550-51, (5th Cir. 1978).

3. Sham actions should not be protected by the state action doctrine.

The state action doctrine provides an exemption from liability under the antitrust laws. There is an analogous exemption from liability, the *Noerr-Pennington* doctrine, for petitioning the state or any branch of government to act. *Eastern Railroad Presidents Conference v. Noerr Motor Freight Inc.*, 365 U.S. 127 (1961); *United Mine Workers of America v. Pennington*, 381 U.S. 657 (1965).

This exemption derives from the First Amendment right to petition the government. Nevertheless, this Court has said there is an exception to the *Noerr-Pennington* exemption for sham conduct.

"There are many other forms of illegal and reprehensible practice which may corrupt the administrative or judicial processes and which may result in anti-trust violations. * * * Abuse of those processes [has] produced an illegal result, viz., effectively barring respondents from access to the agencies and courts. Insofar as the administrative or judicial processes are involved, actions of that kind cannot acquire immunity by seeking refuge under the umbrella of 'political expression.'" *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 513 (1972)

We respectfully suggest that neither should they acquire immunity by seeking refuge under the umbrella of "state action."

4. In any event, there is no immunity for the other defendants.

Even if this Court were to find that Dr. Russell were exempt from liability for anything he did in connection with the Board of Medical Examiners, and therefore entitled to reversal for that reason of the judgment of the District Court, it does not follow that his partners who were in conspiracy with him should also be excused. This Court has held that even if a defendant were entitled to absolute judicial immunity for his own conduct, those who were not judges and who conspired with him have no immunity. *Dennis v. Sparks*, 449 U.S. 24, 27, 31-32 (1980).

E. The courts should not alter the balance between peer review and antitrust which the state legislators and Congress have struck.

Defendants and their allies have argued and continue to argue that participants in peer review should be immune from liability, even if they act in bad faith. That is a decision, however, for the legislatures and for Congress to make. There is no doubt that the Oregon legislature could change Oregon law to expand the provision for statutory

immunity in peer review to protect bad faith actions as well as good faith actions. There is no doubt that the Oregon legislature could articulate a different policy and provide for active state supervision of that policy, so that whatever was done in peer review would indisputably amount to state action. Unless and until it does so, however, there is no reason for the courts to second guess the balance which the legislature has struck. That balance reflects an awareness of two principles. First, peer review is important to the quality of patient care. Second, peer review can be abused, with consequences which are harmful not only to patient care but also to competition and economic freedom.

Congress itself has struck the same balance. 42 U.S.C.A. § 11112(a). As we pointed out in our petition for certiorari, pp. 9-11, Congress enacted a statute dealing with peer review, in partial response to the decisions in this case below. We demonstrated that Congress expressly considered the Ninth Circuit's choice to immunize bad faith peer review, and expressly rejected that choice. This Court should too.

CONCLUSION

The Court should hold that the state action doctrine does not immunize defendants' conduct, and reverse. The Court should remand to the Ninth Circuit for disposition of the remaining issues in the case.

Respectfully submitted,
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RESPONDENT'S

BRIEF

JAN 8 1988

JOSEPH F. SPANIOLO, JR.,
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In the Supreme Court of the United States

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, M.D.,
Petitioner,

v.

WILLIAM M. BURGET, M.D.,
JEFFREY M. LEINASSAR,
As Personal Representative of
JORMA M. LEINASSAR, M.D., Deceased,
R. G. KETTELKAMP, M.D.,
PATRICK MEYER, M.D.,
GARY M. BOELLING, M.D.,
ROBERT D. NEIKES, M.D.,
FRANKLIN D. RUSSELL, M.D.,
LEIGH C. DOLIN, M.D.,
RICHARD C. HARRIS, M.D.,
DANIEL M. RAPPAPORT, M.D.,
and TZU SUNG CHIANG, M.D.,
doing business as ASTORIA CLINIC,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RESPONDENTS' BRIEF

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QUESTIONS PRESENTED FOR REVIEW

1. Whether hospital-based peer review is pursuant to a clearly articulated policy of and is actively supervised by the State of Oregon?

2. Whether there is a clearly articulated policy of the State of Oregon requiring one of its agencies, the Board of Medical Examiners, to displace competition among physicians with regulation?

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

NO. 86 - 1145

Timothy A. Patrick, M.D.
Petitioner,

v.

William M. Burget, M.D.,
Jeffrey M. Leinassar,
as Personal Representative of
Jorma M. Leinassar, M.D., Deceased,
R. G. Kettelkamp, M.D.,
Patrick Meyer, M.D.,
Gary M. Boelling, M.D.,
Robert D. Neikes, M.D.,
Franklin D. Russell, M.D.,
Leigh C. Dolin, M.D.,
Richard C. Harris, M.D.,
Daniel M. Rappaport, M.D.,
and Tzu Sung Chiang, M.D.,
doing business as Astoria Clinic,
Respondents.

RESPONDENTS' BRIEF

STATUTES INVOLVED IN THIS CASE

Or. Rev. Stat. § 41.675.¹

Or. Rev. Stat. § 244.120.²

Or. Rev. Stat. §§ 431.110, 431.120, 431.140, 431.150, 431.155, 431.157, 431.160, 431.170, 431.190.

Or. Rev. Stat. §§ 441.015, 441.022, 441.025, 441.030(2), 441.037, 441.055, 441.705, 441.710, 441.715, 441.820.

Or. Rev. Stat. §§ 677.015, 677.095, 677.190, 677.200, 677.202, 677.205, 677.208, 677.235, 677.275, 677.280, 677.320, 677.325, 677.330, 677.335, 677.415, 677.420, 677.425, 677.435.

¹Text set forth at App. 1-3, Appendix to this Brief.

²All other cited statutes are set forth in Respondents' Appendix to their Brief in Opposition.

I.

STATEMENT OF THE CASE

Petitioner presents the facts at length. For present purposes, it avails little to engage in point/counterpoint refutation. While there is conflicting evidence on peripheral issues, this statement will focus on evidence at the heart of this appeal: the "state action" attributes of hospital-based and Board of Medical Examiner-based peer review.

A.

Review by the Board of Medical Examiners
of the State of Oregon

The Board of Medical Examiners (BOME) is a state agency (App. 37-39).¹ Its members are appointed by the Governor and confirmed by the State Senate.

¹Footnote reference to App. is to the Appendix to Respondents' Brief in Opposition.

The BOME has complete regulatory authority over the practice of medicine in Oregon. Physicians and health care facilities are compelled to report to the BOME if the practice of any physician is, "or may be," not competent or in keeping with the ethical standards of the profession. Or. Rev. Stat. § 677.415(1). The BOME has statutory authority, subject to judicial review, to discipline physicians, including revocation of physicians' privileges to practice in Oregon. Or. Rev. Stat. §§ 677.190, 677.208, 677.415-470.

On November 15, 1979, the Executive Committee of the medical staff of the Columbia Memorial Hospital (Hospital) referred Dr. Patrick's handling of the Willie case to the BOME (Tr. 2231-2232). The Executive Committee believed Dr. Patrick's conduct in that case raised

concerns about possible patient abandonment.

The BOME commenced its investigation by subpoenaing the Willie patient charts, as well as others, from the Hospital, and reviewing those charts (Tr. 2422). On January 2, 1980 Dr. Patrick and his associate, Dr. Weber, were interviewed by the BOME's Investigative Committee (Tr. 714).

On January 10, 1980 the BOME received a preliminary report from Dr. Franklin Russell, Chairman of the Investigative Committee (Tr. 1160). The report framed two issues for the BOME's consideration. The first was Dr. Patrick's and Dr. Weber's treatment of Mr. Willie; and the second was Dr. Patrick's "possible incompetence, malpractice or unprofessional behavior with other cases."

In presenting this report, Dr. Russell announced, pursuant to Or. Rev. Stat. § 244.120 (App. 1-3), that he might have a conflict of interest because both he and Dr. Patrick had been employed by the Astoria Clinic eight years earlier; and both were members of the same community and medical staff (Tr. 745). Consequently, Dr. Russell recused himself from voting but not from participation in deliberations.

Dr. Patrick appeared at the BOME's January 10 meeting. In response to the Board's inquiry, he admitted abandonment of his patient, Mr. Willie (Ex. 38; Tr. 1024).

After this meeting the BOME's Investigative Committee interviewed five physicians and two non-physicians. For example, Dr. Stull testified that Dr. Patrick had abandoned patients after performing major elective surgery; performed surgery outside his field of

competence; and failed to obtain timely consultations (Tr. 2344-2356). Dr. Simmons reported that Dr. Patrick had abandoned patients; had performed procedures on asymptomatic patients; had handled cases more appropriately treated in better equipped hospitals; and had committed misdiagnoses and technical errors (Ex. 1149; Tr. 1068).

Two outside consultants, Dr. Jack Battalia and Dr. Hugh Lawrence, were retained by the BOME. Dr. Battalia concluded that three of Dr. Patrick's cases represented "abandonment with poor judgment in operating and then leaving town"; that Dr. Patrick should have transferred several cases to a tertiary hospital rather than attempting to perform complicated surgery in a secondary hospital; and that because there were insufficient thoracic and vascular cases in Astoria for Dr. Patrick

to retain competence in those fields, such cases should be transferred elsewhere (Ex. 173; Tr. 1032, 1075).

The second consultant, Dr. Hugh Lawrence, advised the BOME that Dr. Patrick's charts present

"* * * significant and real deficiencies in the pathology notes, autopsy reports, operative notes, and progress notes which make an analysis of patient care deficiencies difficult if not impossible." (Ex. 174; Tr. 1032-1033)

At its April 12, 1980 meeting, the BOME voted unanimously to send a letter of reprimand and constructive criticism to Dr. Patrick (Tr. 748-749, 999, 1085, 1089). Dr. Russell abstained from this vote (Tr. 748-749).

The reprimand letter stated that the Board had reviewed 15 charts. Those charts raised serious concerns, including abandonment of Mr. Willie; his need to

obtain earlier consultations; the scope of his surgical privileges; his staff relations; and his maintenance of appropriate vascular and thoracic competence. The Board concluded by reprimanding Dr. Patrick with respect to the Willie case and expressing its hope that Dr. Patrick would take its comments seriously and conform his conduct accordingly (Ex. 51; Rec'd Tr. 262-263).

At the same time, the BOME issued a letter to Hospital chastising it for a variety of problems, including lax grant of surgical privileges; failure to undertake audits; and possible curtailment of privileges. The BOME concluded by offering to meet with the governing body of the Hospital to address these concerns (Ex. 1189; Rec'd Tr. 553, 964).

On May 13, 1980 Dr. Patrick admitted the Board's reprimand was proper with

respect to the Willie case but questioned review of charts of his other patients because he had not been granted an opportunity to review and discuss these (Ex. 54; Rec'd Tr. 268). On June 6, 1980 the BOME informed Dr. Patrick of the identities of those additional patients (Ex. 55; Rec'd Tr. 270).

On August 12, 1980, the BOME met. Its Chairman, Dr. Tanaka, informed members that Dr. Patrick had objected to the portions of the reprimand letter relating to subjects other than the Willie case (Ex. 1229; Rec'd Tr. 1089); and that Dr. Patrick had demanded that the BOME form an independent ad hoc committee to review these cases or legal action would be taken.

Dr. Russell responded to Dr. Patrick's criticism by arguing to the other members of the BOME: (1) Dr. Patrick was reprimanded solely for the Willie case;

(2) the balance of the letter was not based merely upon chart review, but on other information, including interviews with five physicians and two non-physicians plus other information, gathered by the investigator; and (3) it would not be possible to form an independent ad hoc committee without violating the statutory privilege for complainants and witnesses.

Dr. Russell characterized the balance of the letter as simply advice which Dr. Patrick could accept or disregard and, if he felt aggrieved, judicial review was available.

Following the discussion, Dr. Tanaka suggested meeting with Dr. Patrick and the Board consultant, Dr. Battalia. He further suggested that Dr. Battalia and Dr. Patrick should review Dr. Patrick's charts for educational purposes, if this could be accomplished without breaching

confidentiality. The Board adopted this proposal (Exs. 1229, 1231; Rec'd Tr. 1004, 1089).

The meeting was held on September 2, 1980 between Drs. Patrick, Tanaka, Battalia, and Mr. Marmaduke, Dr. Patrick's legal counsel. Each chart was reviewed. The participants concluded Dr. Patrick's handling of two or three cases in addition to the Willie matter deserved criticism (Tr. 974).

On October 11, 1980 a final meeting of the BOME was conducted. Dr. Tanaka reported his conclusions. He stated that in some instances, where the charts were the sole basis for the Board's criticisms, those criticisms may have been overstated. However, there were still valid concerns regarding Dr. Patrick's professional conduct: a sparsity of formal consultation, egotism, and performance of

specialty procedures inappropriate to a rural community (Tr. 1009).

At the end of this meeting, the BOME unanimously declined to modify its reprimand letter (Ex. 170; Rec'd Tr. 1017; Tr. 1013-1014). In response, Dr. Patrick filed a Petition for judicial review of the BOME's determination, as well as a civil claim for damages against the BOME (Tr. 557-558; Ex. 149; Rec'd Tr. 277-278).

In December, 1981 the BOME withdrew its reprimand letter (Tr. 278, 982; Ex. 114; Rec'd Tr. 278), notwithstanding that the Board's criticism of his treatment of Mr. Willie were valid. The BOME, however, informed Dr. Patrick it would continue to monitor his practice (Tr. 1091).

Hospital-Based Peer Review Proceedings

In November, 1981 Dr. Patrick performed the second of two unwarranted surgeries on a 15-year-old boy, Stuart Snodgrass. Every doctor who reviewed his treatment of this patient agreed it was inappropriate (Tr. 247, 756, 823, 2142, 2279-2287, 2357; Ex. 1280; Rec'd Tr. 2317).

Request was made to the Executive Committee to take corrective action based upon this case and numerous prior incidents (Ex. 1274; Rec'd Tr. 574).

The Executive Committee formed an Investigatory Committee, which conducted interviews of nurses and doctors, including Dr. Patrick, and reviewed Dr. Patrick's practice (Exs. 1276, 1280-1281; Rec'd Tr. 576, 2205, 2317). The Committee recommended that corrective action be taken. It forwarded its recommendation to

the Executive Committee (Tr. 2517; Ex. 1289; Rec'd Tr. 578) which, after granting Dr. Patrick a hearing,² decided that his privileges should be terminated (Ex. 1292; Rec'd Tr. 730).

Pursuant to the Hospital's Bylaws, Dr. Patrick requested a hearing regarding this decision. The Executive Committee appointed an ad hoc committee to consider this matter. Under the Bylaws, that committee had authority to recommend confirmation, rejection or modification of the Executive Committee resolution (Ex. 156; Rec'd Tr. 304).

Dr. Patrick, who wished to prevent the formation of the ad hoc committee, objected to the composition of the committee, alleging that most of its members were

²He claimed his only mistake in the Snodgrass case was "being caught" (Tr. 2518).

biased (Tr. 556, 1717-1719). After receipt of legal counsel, the committee, with two exceptions, adhered to its original composition (Tr. 1720, 1746; Ex. 1324; Rec'd Tr. 1719).

The hearing commenced on November 23, 1981 (Tr. 1192). It lasted 17 sessions, until April 1982, totaling roughly 60 hours (Tr. 1723).

Two primary expert witnesses testified regarding Dr. Patrick's competence. First, petitioner's expert, Dr. Warrenton, disagreed that Dr. Patrick's cases justified revocation of privileges, but concurred that the Hospital's decision to investigate Dr. Patrick's practice was reasonable (Tr. 791). He further testified that Dr. Patrick's handling of several cases was inappropriate; the Patterson case should have been treated differently (Tr. 793-794); the Bode, Kemmer and Nygren

cases represented misdiagnoses (Tr. 798, 809, 816); the Partridge case should have been referred to a gynecologist, and there was no chart evidence justifying the procedure performed; in the Broderick case, the failure to aspirate the patient's stomach probably contributed to his death (Tr. 821-823); and that the Snodgrass case involved a "major misdiagnosis" which there was "no way to defend" (Tr. 823).

Second, Dr. Alberty, the Executive Committee's expert, agreed Dr. Patrick had committed a series of misdiagnoses and technical errors (Tr. 2249, 2252-2253, 2257, 2260, 2262, 2264, 2266, 2270, 2272, 2275, 2278). Given these errors, Dr. Alberty concluded the Hospital was obligated, at a bare minimum, to put him on probation and compel him to participate in consultation on elective surgery and in post-consultations on emergency cases. He

concluded by stating that the Snodgrass case alone warranted probation (Tr. 2300).

Dr. Patrick did not testify during the sessions. At the final session Dr. Patrick, after proclaiming the panel was biased against him, tendered his resignation from the Hospital (Tr. 354-357; Ex. 127). The proceedings then were adjourned.

The ad hoc committee was not empowered to take final action. Under the Hospital's Bylaws, any recommendation from the ad hoc committee had to be approved by the Board of Trustees of the Hospital (Ex. 156; Rec'd Tr. 304). There was no evidence that members of the Board of Trustees held any bias against Dr. Patrick. There was substantial contrary evidence (Tr. 607-609, 2188-2190; Ex. 1315; Rec'd Tr. 1190).

Strict procedures governed appeal to the Trustees (Section 6(E), (G) of Ex. 156;

Rec'd Tr. 304). Under these rules Dr. Patrick had the right to raise two issues:

1. Whether, as a procedural matter, the panel members were biased; and
2. Whether the evidence adduced warranted any form of corrective action.

Since Dr. Patrick terminated the review process in mid-course, the Trustees never had the opportunity to consider these issues.

C.

Anticompetitive Intent

Petitioner states that the jury must have found that the respondents possessed an anticompetitive motive. Because of conflicting instructions, it is impossible to divine the basis of the jury's verdict. The jury was, however, instructed in part:

"Whether the particular restraint was reasonable or unreasonable does not turn merely

on the purpose (sic) of a sound business purpose -- that is, the presence of a sound business purpose or motive for imposing the restraint. An unreasonable restraint may result even though defendants apparently act for sound business reasons and without any predatory intent to injure competitors. You should consider evidence of purpose or motive only insofar as it may assist you in interpreting defendants' conduct and determining or predicting the effects of that conduct upon competition. However, if you find that the conduct and practices of the defendants as alleged by the plaintiff had the effect of unreasonably restraining trade, then the antitrust laws have been violated regardless of the legitimate business purpose or motive." (Tr. 2917, obj. overruled Tr. 2940-2941)

The jury may thus have concluded that "unreasonable effects" alone were sufficient to impose antitrust liability.

II.

SUMMARY OF ARGUMENT

To what extent does the state action doctrine shelter proceedings before a state

board of medical examiners and hospital-based peer review proceedings from antitrust scrutiny? What is the proper relationship between the Sherman Act and a comprehensive state-mandated system of physician peer review?

These questions, at the heart of this case, constitute the very essence of federalism. If participants in peer review systems are subject to federal antitrust liability, then state regulation of professional medical competence, a fundamental local concern, will be frustrated and subverted.

Complainants -- patients, staff members and other physicians -- will be fearful of reporting on perceived deficiencies of a physician if it is known that their confidential communications may become a public record and the basis of liability.

Physicians will refuse to engage in peer review of one another if they know that a jury may attempt to second guess their subjective intent and judgment at some future point. Individuals -- lay members and physicians -- will refrain from serving on the various boards regulating professional competence and responsibility.

This is not a "parade of horrors." It is, rather, reality -- the inevitable result unless participants in the process are assured, through application of the state action doctrine, that they will neither be required to defend, nor be subjected to liability for their actions.

Hospital peer review in the state of Oregon is the creature of statute. The statutory scheme contemplates supplanting the free-for-all of market competition with regulation of access to, and retention of, staff privileges. The state agencies and

the Oregon courts supervise the results of this process.

The BOME is a state agency. It regulates access to, and retention of, licenses to practice medicine.

The state of Oregon has clearly articulated a policy that, because of public health and safety concerns, marketplace economics should not determine who will practice medicine. Rather, professional competence should define an entitlement to practice.

Consistent with these policies, complainants and witnesses who have acted under compulsion of state law are immune from liability except the criminal consequences of perjury. Without these protections, the system will fail.

Confidentiality is also essential to effective regulation of professional competence. To interpret Fed. R. Evid. 501

to countenance public disclosure of BOME proceedings (as did the District Court here) disrupts settled expectations of privacy protected under state law. Oregon citizens, caught between assurances of confidentiality under state law and the potential for compelled disclosure under federal law, will refuse to participate in the regulatory process.

III.

ARGUMENT

A.

The State Action Doctrine

Shelters Hospital-Based Peer Review from the Antitrust Laws

As described previously, pp. 14-19, supra, after the Snodgrass case, the medical staff of Columbia Memorial Hospital reviewed Dr. Patrick's practice and privileges. Shortly after the medical staff's Executive Committee announced its

intention to revoke Dr. Patrick's privileges, this lawsuit was filed.

The Hospital ad hoc hearing panel subsequently conducted 17 hearings, but Dr. Patrick resigned staff privileges before those proceedings were complete.³

The state of Oregon has enacted a complex statutory scheme to protect the public against the unregulated practice of

³Before Dr. Patrick filed suit he was required to exhaust the peer review process mandated by the Hospital Bylaws. Acceptance of these Bylaws was a condition of a grant of privileges. He chose to resign rather than to complete the process, asserting futility. While the Ninth Circuit declined to rule on this issue, Dr. Patrick's failure to exhaust constitutes a separate ground for affirming the Ninth Circuit's decision. Westlake Community Hospital v. Superior Court of Los Angeles, 551 P.2d 410, 416 (Cal. S. Ct. 1976). The substantive antitrust and federalism issues need not be reached if the appeal is resolved on this issue. See also Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985) and Gemco Latino America, Inc. v. Seiko Time Corp., 1987-2 Trade Cases ¶ 67,770 (U.S.D.C. N.Y. 1987).

medicine. The State recognized that the absence of regulation created the potential for unacceptable human loss. The State delegated to hospitals mandatory peer review to weed out incompetent and dangerous physicians. It assigned two agencies and the state Courts supervision of the process.

Analysis of the state action doctrine commences with Parker v. Brown, 317 U.S. 341 (1943). There the Court recognized the need to respect the legislative decisions of states acting in their sovereign capacity. Consistent with this federalism premise, the Court concluded that the conduct of states acting as sovereigns could not support antitrust liability.

In Southern Motor Carrier Rate Conference, Inc. v. United States, 471 U.S. 48 (1985), the Court emphasized that Parker's immunity extends not just to

public officials, but to private parties who participate in state regulatory systems:

"* * *. The Parker decision was premised on the assumption that Congress, in enacting the Sherman Act, did not intend to compromise the State's ability to regulate their domestic commerce. If Parker immunity were limited to the actions of public officials, this assumed congressional purpose would be frustrated, for a State would be unable to implement programs that restrain competition among private parties. A plaintiff could frustrate any such program merely by filing suit against the regulated private parties, rather than the state officials who implement the plan. We decline to reduce Parker's holding to a formalism that would stand for little more than the proposition that Porter Brown sued the wrong parties. (Citations omitted.)" Ibid. 56-57.

Thus concepts of federalism are to be applied in such a way as to ensure "fairness for the private defendant caught in the conflicting structures of a federal system." 1 P. Areeda & D. Turner,

Antitrust Laws, § 217, p. 109 (1978), See also, Thomas M. Jorde, "Antitrust and the New State Action Doctrine: A Return to Deferential Economic Federalism," 75 Cal. L. Rev. 227 (1987).

In addressing the fit of Oregon's regulation scheme and federal antitrust liability, these dual concerns -- implementation of state policy and fairness to individuals' attempts to comply with those policies -- must control.

Commencing in the mid-70's courts refined the state action doctrine. Two issues became important: Who was the sovereign?⁴ and, to what extent and under what circumstances private actors were entitled to claim derivative shelter?

⁴City of Lafayette, La. v. Louisiana Power & Light Co., 435 U.S. 389 (1978); Hoover v. Ronwin, 466 U.S. 558 (1984); and Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

Southern Motor Carrier Rate Conference, Inc. v. United States, 471 U.S. 48 (1985); California Motor Transport Co. v. Trucking Unlimited, 404 U.S. 508 (1972).

Focusing on the second issue, where the conduct involved that of a private party, this Court formulated a two-pronged test: First, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; and second, the policy must be actively supervised by the state itself. California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

All parties agree that the Midcal standard controls hospital-based peer review. They disagree over whether the Oregon statutory scheme meets its requirements.

Before proceeding to analyze application of the two-prong test, certain

general concerns must be discussed. It is the public policy of the state of Oregon that

"* * * any person serving on or communicating information to the governing body of the hospital or committee thereof shall not be examined in judicial proceeding as to any communication to that committee or the findings thereof." Or. Rev. Stat. § 41.675(2).

This statute expresses an important state policy. However, under the District Court's interpretation of Fed. R. Evid. 501, see infra, pp. 66-71, the mere filing of a federal antitrust claim eviscerates confidentiality guaranteed under Oregon law.⁵

⁵Should the Court interpret Fed. R. Evid. 501 to require, as a matter of comity or federalism, respect to be granted to the Oregon legislative mandate of confidentiality in hospital-based peer review proceedings, the decision of the Ninth Circuit must be affirmed, infra, pp. 66-71.

Application of the Sherman Act urged by petitioner will create inconsistencies in the operation of state law. The rights and expectations of physicians whose practices do not implicate interstate commerce will be governed exclusively by state law. Conversely, those physicians who, by fortuity, are engaged in a "not insubstantial" volume of interstate commerce will be consigned to a "twilight zone." Only after the "interstate nexus" issue is resolved in an antitrust suit -- and only after discovery of otherwise privileged information -- will physicians learn whether they are subject to federal law.

This confusion is further exacerbated by the federal circuits' differing view regarding the requisite impact on interstate commerce to trigger the Sherman

Act.⁶ Compare Seglin v. Esau, 769 F.2d 1274 (7th Cir. Ill. 1985), with Western Waste Service Systems v. Universal Waste

⁶There is a split among the federal courts of appeal as to whether the jurisdictional nexus to interstate commerce is satisfied if the plaintiff establishes that either party's activities "generally affect" commerce or only if the plaintiff alleges that the defendants' misconduct affects interstate commerce in a not insubstantial way. The correct rule as recognized by the First, Second, Sixth, Seventh, Eighth, and Tenth Circuits is that the restraint imposed by the defendant affects interstate commerce in "a" not insubstantial way. Hayden v. Bracy, 744 F.2d 1338, 1343 (8th Cir. 1984); Stone v. William Beaumont Hosp., 782 F.2d 609 (6th Cir. 1986); Furlong v. Long Island College Hospital, 710 F.2d 922, 925-926 (2d Cir. n. 8 1983); Cordova and Simonpeietri Insurance Agency, Inc. v. Chase Manhattan Bank N.A., 649 F.2d 36, 45 (1st Cir. 1981); Crane v. Intermountain Health Care, Inc., 637 F.2d 715, 719, 722-24 (10th Cir. 1980). The respondent argued before the Ninth Circuit that proper application of this jurisdictional test would require dismissal. Before any determination on the merits this Court must, of course, determine whether jurisdiction exists. See App. Br. to Ninth Circuit, pp. 54-57, In re Bonner, 151 U.S. 242 (1893) and New Orleans Mail Co. v. Flanders, 12 Wall. (U.S.) 130, 135 (1872).

Control, 616 F.2d 1094, 1097 (9th Cir. 1980), cert. den., 449 U.S. 869 (1980); Cardio-Medical Ass., Ltd. v. Crozer-Chester Medical Center, 721 F.2d 68 (3d Cir. 1983).

1. Hospital Peer Review Was Pursuant to a Clearly Expressed Policy to Supplant Competition with Regulation.

In Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985), this Court amplified the content of the "clearly articulated" standard:

"* * *. It is not necessary, * * * for the state legislature to have stated explicitly that it expected the City to engage in conduct that would have anticompetitive effects. Applying the analysis of City of Lafayette, 435 U.S. 389, 98 S. Ct. 1123, 55 L.Ed.2d 364 (1978), it is sufficient that the statutes authorized the City to provide sewage services and also to determine the areas to be served. We think it is clear that anticompetitive effects logically would result from this broad authority to regulate. See

New Motor Vehicle Board v. Orrin W. Fox Co., 439 U.S. 96, 109, 99 S. Ct. 403, 411, 58 L.Ed.2d 361 (1978) (no express intent to displace the antitrust laws, but statute provided regulatory structure that inherently 'displace[d] unfettered business freedom.') Accord, 1 P. Areeda & D. Turner, Antitrust Law, ¶ 212.3, p. 54 (Supp. 1982)."

What has the Oregon Legislature done which would make it clear that anticompetitive effects logically result from a grant of broad authority to regulate the practice of medicine in hospitals?

First, the State has enacted a comprehensive licensing scheme. Health care facilities, in order to conduct business, must be licensed. Or. Rev. Stat. § 441.015(1). As a condition of licensure, each health care facility is mandated to comply with Or. Rev. Stat. § 441.055(3) (App. 16). The governing body of the hospital must:

"(3) * * * be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility * * *.

"* * * * *.

"(b) Insure that physicians admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications;

"(c) Insure that procedures for granting, restricting, and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law; and

"(d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care." Or. Rev. Stat. 441.055(3) (App. 16-17)

Hospital-based peer review is thus compelled by Oregon statute. Such review may initially result in denial of access to

staff privileges; or, in a restriction in credentials to those which correspond to the physician's experience and education. For physicians granted privileges, peer review may result in various forms of discipline, including termination of privileges, if the practitioner's conduct does not conform to the standards of care within the community.

The regulations, which hospitals must follow, establish a system of peer review by competitors of competitors. While termination of a physician's privileges at a specific hospital may be pro-competitive in competition between hospitals, inevitably, necessarily, the regulatory scheme has an anticompetitive impact among physician competitors. Marrese v. Interqual, Inc., 748 F.2d 373, 378 (7th Cir. 1984), cert. den., 472 U.S. 1027 (1985); Coastal Neuro-Psychiatric

Associates, P.A. v. Onslow Memorial Hospital, Inc., 795 F.2d 340, 342 (4th Cir. 1986). Peer review thus promotes a "clearly articulated" state policy choice to regulate competition among physicians within a hospital.

Petitioner seeks to avoid this fact by arguing that conduct motivated by some subjective "anticompetitive intent" can never be pursuant to state policy. If this were so, the state action doctrine would be meaningless.

Petitioner's position would require analysis, on a case-by-case basis, of the subjective intent of each actor. For each case, a jury would be required to assess "intent", as a factual matter, to determine whether immunity applied. State action immunity, as a matter of law, would be abolished.

In Hoover v. Ronwin, 466 U.S. 558 (1984) this Court recognized these concerns. This Court noted that emphasis on "motive" undercuts the protections of the state action doctrine by forcing otherwise immune defendants to bear substantial discovery and litigation burdens. Indeed, the mere threat of being sued for treble damages would deter able citizens from performing essential public service. Ibid. at 466 U.S. 558, 581.⁷

⁷Professor Areeda commented:

"A contrary conclusion would compel the federal courts to intrude upon internal state affairs whenever a plaintiff could present colorable allegations of bad faith on the part of the defendants." Areeda, "Antitrust Immunity for 'State Action' After Lafayette," 95 Harv. L. Rev. 435, 453 (1981).

See also Llewellyn v. Crothers, 765 F.2d 769, 774 (9th Cir. 1985), Kennedy, J.

In conclusion, this Court should hold that the State of Oregon has expressed its intention to regulate competition among medical staff members through hospital-based peer review. Midcal's first prong has been satisfied.

2. The State of Oregon Actively Supervises Hospital-Based Peer Review.

The second prong of the state action doctrine, as applied to private actors, compels a showing that their conduct is subject to "active supervision." The Ninth Circuit correctly concluded that the combination of agency and judicial review in this case satisfied this standard.

Oregon statutes display such active supervision. As a licensee, Hospital is

subject to supervision by the Health Division of the State of Oregon.⁸

The Division is required to enforce state health policies and rules. Or. Rev. Stat. § 431.120(1) (App. 4).

Local health officials designated by the State are charged with

"* * * strict and thorough enforcement of the public health laws of this state in their districts, under the supervision and direction of the Health Division. * * *." Or. Rev. Stat. § 431.150(1) (App. 6).

These officials must report to the Division any violation of such laws which is observed or "upon complaint of any person." Or. Rev. Stat. § 431.150(1) (App. 6).

⁸Or. Rev. Stat. § 431.110 states that the Health Division shall

"(1) Have direct supervision of all matters relating to the preservation of life and health of the people of the state." (App. 3)

Under Or. Rev. Stat. § 431.150, the Division may request local district attorneys to initiate and prosecute actions in state courts against offending parties. Or. Rev. Stat. § 431.150 (App. 6-7). The Division is also empowered to obtain injunctive relief for violation of any statute administered by the Health Division. Or. Rev. Stat. § 431.155(1) (App. 8).

Any licensed hospital that fails to undertake peer review under Or. Rev. Stat. § 441.055 or that fails to apply peer review proceedings properly is, itself, in violation of Oregon's health laws (App. 15-17). If, as Dr. Patrick contends, there were inherent flaws in the peer review proceedings, he should have filed a complaint with the Health Division. If the Division concurred, it could have obtained injunctive relief against the Hospital (Or.

Rev. Stat. § 431.150(1)); caused the District Attorney or the State Attorney General to take immediate remedial action, and revoked the Hospital's license. Or. Rev. Stat. § 441.030(2) (App. 14).

Under this statutory scheme, the Health Division had active supervisory authority over hospital-based peer review.

"Active supervision" is not limited to the Health Division of the state of Oregon. The Oregon Legislature granted the BOME broad authority to regulate the practice of medicine. The Legislature found that such supervisory authority promoted the interests of health, safety, and welfare of the people of Oregon. Under Or. Rev. Stat. § 677.015, the BOME is empowered:

"* * * to provide for the granting of that privilege and the regulation of its use, to the end that the public is protected from the practice of medicine by unauthorized or unqualified persons and from unprofessional

conduct by persons licensed to practice under this chapter." Or. Rev. Stat. § 677.015 (App. 24)

Pursuant to this mandate, the BOME has authority to regulate the grant of license, the terms and conditions of licensure and its curtailment or loss. Or. Rev. Stat. § 677.015 (App. 24)

How does hospital-based peer review interface with the statutory scheme governing the BOME? First, any hospital which restricts or terminates the privileges of a physician is compelled to report this event and all material facts to the BOME in writing. Or. Rev. Stat. § 441.820(1) (App. 23-24). Second, all health care facilities and licensees are compelled to report to the BOME conduct which "is, or may be, medically incompetent or is, or may be, unprofessional or of dishonorable conduct nature." Or. Rev.

Stat. § 677.415(1) (App. 46). Third, malpractice insurers are required to report to the BOME and to the state Insurance Commissioner medical malpractice claims, with copies to hospitals. Or. Rev. Stat. §§ 677.435 (App. 50-51), 743.770.

This statutory reporting scheme does not explicitly provide for a reversal of a hospital's decision to restrict or revoke privileges. However, the required reporting triggers the BOME's review of the "facts and circumstances which relate to the decision."

Further, the statutes provide another curative means for redress. The respondents, in connection with peer review at the Hospital, stand accused of unprofessional or dishonorable conduct. If there were evidence to support such a contention, an accused physician is subject to suspension or revocation of his license

to practice (Or. Rev. Stat. § 677.190; App. 25-30); and Dr. Patrick was compelled to report this conduct pursuant to Or. Rev. Stat. § 677.415(1).

Finally, judicial supervision of the peer review process by Oregon courts shows "active supervision."

Review of the Oregon statutory and common law yields the following conclusions:

a. The Oregon Legislature intended that physicians be afforded judicial review of suspension or revocation of staff privileges. Or. Rev. Stat. § 41.675(5). 1981 Oregon Laws, C. 806 § 1. (App. to this Brief, App. 1-3.)

Prior to enactment of this section in 1981, peer review evidence was absolutely privileged -- it was inadmissible in any judicial proceeding. However, Or. Rev. Stat. § 41.675(5) expressly permits

introduction of medical charts and other peer review documents in a

"* * * judicial proceedings in which a health care practitioner contests the denial, restriction or termination of clinical privileges by a health care facility. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding."
[Emphasis supplied.]

The state court thus acts as a supervisory arm of the state to compel compliance with the peer review statutes.⁹

b. Finally, on two occasions the Oregon courts have reviewed privilege decisions to determine whether they were

⁹The legislative history states:

"* * * subsection 5, provides for the physician as a party in legal proceedings, against the hospital for instance, to whom he is aggrieved by the action of the governing board then has this data available to him for that judicial proceeding. . . ."
Peter Fleissner, H.B. 2443, 1981 Senate Justice Comm. Minutes, 7/22/81, Tape 312, Side A.

made in good faith pursuant to fair procedures and were supported by the facts. Straube v. Emanuel Lutheran Charity Board, 287 Or. 375, 600 P.2d 381, 386-87 (Or. 1979), cert. den., 445 U.S. 966 (1980); Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398, 1401 (Or. 1975).

Petitioner and amici recognize that Oregon courts have reviewed privilege decisions, but argue that unless such review is de novo, it does not satisfy Midcal's "active supervision" requirement.

There are two problems with petitioner's position. First, a court need not engage in de novo judicial review of privilege decision to satisfy the "active

supervision" requirement.¹⁰ Review by a state court may properly be limited to whether there was substantial evidence to support the peer review decision. This type of review supervises the underlying process and assures compliance with state policy.¹¹

Second, Oregon courts have engaged in de novo review with respect to questions of due process. In Straube and Huffaker, the Oregon courts discussed and applied the

¹⁰Jain v. Northwest Community Hospital, 385 N.E.2d 108, 111-12 (Ill. App. 1st Dist. 1978); Greisman v. Newcomb Hospital, 192 A.2d 817 (N.J. 1963); Applebaum v. Board of Directors of Barton Memorial Hospital, 104 Cal. App. 3d 648 (1980).

¹¹Williams v. Kleaveland, 1983-2 Trade Cases ¶ 65,486 at 68,357 (W.D. Mich. 1983). See also Sosa v. Board of Managers of Valverde Memorial Hospital, 437 F.2d 173, 177 (5th Cir. Tex. 1971); Peterson v. Tucson General Hospital, Inc., 114 Ariz. 66, 559 P.2d 186, 192 (1976); Zoneraich v. Overlook Hospital, 212 N.J. Super. 83, 514 A.2d 53, 57 (N.J. Super. A.D. 1986).

common law right of fair procedure. See 287 Or at 379-80, 273 Or at 276.

B.

Evidence of BOME Proceedings Was Inadmissible as Immaterial under the State Action Doctrine and as Privileged Under Fed. R. Evid. 501 and Oregon Law

1. Overview and General Principles.

The BOME is a state agency. Or. Rev. Stat. § 677.235 (App. 37-40). Its members are appointed by the Governor and confirmed by the State Senate.

The BOME has complete regulatory authority over the practice of medicine in Oregon. Practitioners and health care facilities are compelled to report to the BOME if the practice of any physician is, "or may be," not competent or not in keeping with the ethical standards of the profession. Or. Rev. Stat. § 677.415(2) (App. 47). A licensee who fails to report

the actions of another licensee is himself subject to discipline. Or. Rev. Stat. § 677.190(18) (App. 29).

The BOME has authority, subject to judicial review, to discipline or revoke the privilege of a physician to practice in Oregon. Or. Rev. Stat. § 677.205 (App. 32-33).

BOME investigations and hearings are sensitive. The potential of libel and slander claims, regardless of merit, against complainants and unwarranted damage to accused physicians' reputations documents its wisdom. To promote the Board's performance of its statutory purposes, Oregon law guarantees the confidentiality of BOME proceedings:

"Any information provided to the board pursuant to ORS 677.200, 677.205, 677.410 to 677.425 or 677.860 is confidential and shall not be subject to public disclosure, nor shall it be admissible as evidence in any

judicial proceeding." Or. Rev. Stat. § 677.425(1) (App. 49-50)

This legislative restraint proved prudent. The number of complaints filed annually with the BOME escalated from 300 to 1,500 after the confidentiality provision was included (Tr. 743) (App. 49-50).

The Oregon Legislature also armed the BOME with substantial administrative authority, including subpoena power, miscellaneous discovery powers, and the like. Or. Rev. Stat. § 677.320 (App. 42-43). To ensure the vigor of the BOME's actions, the Legislature conferred judicial immunity on the Board, members of its administrative and investigative staff and its attorneys. Finally, the Oregon Legislature conferred civil immunity to complainants and witnesses before the Board. Or. Rev. Stat. § 677.335 (App. 45-46).

In this case, these statutory policies and protections collide with the District Court's construction of the Sherman Act. This is precisely the sort of collision, a federalism tension, that the state action doctrine was designed to avoid. In this case, the BOME, over vigorous protest, was forced to disclose its confidential records under compulsion of a Federal Court subpoena (R 83). The BOME's Executive Director was compelled, by subpoena, to give testimony with respect to the BOME's deliberations (R 83). The identity and testimony of witnesses, who had appeared before the BOME under promise of privilege, were disclosed. The confidentiality of BOME deliberations in which members deliberated as quasi-judicial officers, was compromised. These steps were allowed under the premise that Fed. R. Evid. 501 was dispositive.

The sole purpose for violating the confidentiality of Board proceedings was to permit petitioner to pursue antitrust claims against Dr. Russell, a member of the Board, and against other respondents who appeared as witnesses before the Board. The sole justification for this Federal Court-ordered breach of state-mandated confidentiality was the District Court's construction of Fed. R. Evid. 501.

The admission of evidence of BOME proceedings was improper for two reasons. First, such evidence was immaterial as a matter of law because, under the state action doctrine, antitrust liability could not be based on participation in BOME proceedings. Second, even if such evidence were material, it is privileged under Fed. R. Evid. 501.

2. Petitioner's "Continuing Combination" Theory.

a. Procedural Posture.

Petitioner asserts he was able to introduce evidence pertaining to proceedings before the BOME because proof of respondents' conduct before the BOME, even if otherwise immunized, was probative of a "continuing combination" in restraint of trade, both before and after the BOME proceedings (Pet. Br. 41-42).¹²

This argument fails for a number of reasons. First, petitioner never asserted

¹²Federal Trade Commission v. Cement Institute, 333 U.S. 683 (1948), relied upon by petitioner, is distinguishable because:

a. The rules of evidence do not control agency proceedings;

b. There was no intent, as here, to impose liability for past conduct; and

c. There was no independent sovereign that had declared such evidence to be inadmissible.

before the Trial Court that this evidence should be admitted as proof of a "continuing conspiracy." The Trial Court did not engage in the delicate balancing test contemplated by Fed. R. Evid. 403 to determine admissibility. Nor was any limiting instruction proposed or given.

Second, the record belies petitioner's claims that he did not assert liability based upon the BOME proceedings. Petitioner did seek damages in connection with the BOME proceedings; i.e., attorneys' fees incurred in the defense thereof (Tr. 371-72, 2751); as well as substantial damages for diminished revenues for the period which preceded Dr. Patrick's resignation from staff privileges in April, 1982 (Tr. 1520, 1522, 1526, 1530, 1553, 1554). Thus, petitioner's "continuing combination" thesis, which was first expressed obliquely in two sentences

of his 119-page Ninth Circuit Brief (p. 82), has nothing to do with how this case was tried.

Finally, the Ninth Circuit did not address admissibility on this theory. The Court limited its focus to the immunity provided for BOME proceedings and never referred to the continuing combination theory. The issue is not properly before the Court.¹³

If, however, the Court concludes evidence of the BOME proceedings is probative of some "continuing combination," principles of federalism are inevitably implicated. Admission of this evidence, for any purpose, cannot be reconciled with the express public policy of the state of Oregon. Such admission would compromise

¹³The Solicitor General apparently agrees. (Solicitor General Brief, p. 5, fn. 5).

the confidentiality of the Board's quasi-judicial deliberations, discouraging free participation of informants and witnesses in the regulatory process.

This conflict can be avoided only through holding either that:

(i) Because of the state action doctrine, such evidence is immaterial to antitrust claims under federal law; or

(ii) Evidence of confidential Board proceedings is inadmissible.

b. Under the State Action Doctrine, Evidence of BOME Proceedings Is Immaterial.

The BOME has authority to license, discipline and revoke the privilege of a physician to practice in Oregon. Or. Rev. Stat. §§ 677.190, 677.208, 677.415-420.

The Board is thus vested with statutory power to replace unfettered market competition between physicians with

regulation. The BOME regulates access to the market to compete with other physicians for the provision of service in Oregon, the terms and conditions of retention of such privilege, and its loss.

In the seminal case of Parker v. Brown, 317 U.S. 341 (1943), the Court derived state action immunity from principles of federalism. There, the supposed "anticompetitive" conduct was immunized from antitrust liability because it was authorized by:

"* * * the legislative command of the state and was not intended to operate or become effective without that command. We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a

state's control over its officers and agents is not to be lightly attributed to Congress." Ibid. 350-351.

It is tempting to conclude the analysis with Parker v. Brown, supra. Defendant there, as was Dr. Russell here, were officers of the state charged with enforcement of the regulatory scheme. His actions were therefore the actions of the sovereign.¹⁴

In Hoover v. Ronwin, 466 U.S. 558, 569 (1984), the Court suggested that if disputed conduct is other than that of the state Legislature or Supreme Court, Midcal's "clear articulation" standard must be met.¹⁵

¹⁴See also Community Communications, Co., Inc. v. City of Boulder, Colorado, 455 U.S. 40, 54 (1982).

¹⁵The "active supervision" component of the Midcal test need not be satisfied. Town of Hallie v. City Eau Claire, 471 U.S. 34 (1985).

The Ninth Circuit, of course, held that the "clear articulation" test was satisfied here. 800 F.2d 1498, 1505. Neither petitioner nor any amici disputes this holding.¹⁶

Petitioner seeks to circumvent the state action doctrine by arguing, alternatively, that

- i. Dr. Russell "recused" himself from participation in the Patrick case; and
- ii. There were "procedural failures" by the BOME in application of the state statutory scheme. See Pet. Br. at 43.

¹⁶The Ninth Circuit's "clear articulation" holding is consistent with those of other courts. Brazil v. Arkansas Board of Dental Examiners, 593 F. Supp. 1354, 1984-2 Trade Cases ¶ 66,243 (E.D. Ark. 1984), aff'd. per curiam, 759 F.2d 674, 1985-1 Trade Cases ¶ 66,565 (8th Cir. Ark. 1986). See also New Motor Vehicle Board of California v. Orrin W. Fox Co., 439 U.S. 96 (1978). Llewellyn v. Crothers, 765 F.2d 769, 774 (9th Cir. 1985).

Dr. Russell was the Chairman of the Investigative Committee. At the outset of the investigation, Dr. Russell announced that he had a potential conflict of interest because he and Dr. Patrick worked together at the Astoria clinic eight years previously and because he and Dr. Patrick were from the same hospital and community (Tr. 2716-245).

Dr. Russell subsequently participated in discussions, but did not vote on the decision to reprimand Dr. Patrick. He assisted in drafting the reprimand letter upon which the entire BOME had previously agreed; and ultimately argued against revision of that letter in response to Dr. Patrick's criticisms. The BOME unanimously decided not to revise the reprimand letter. Again, Dr. Russell did not vote.

Under Or. Rev. Stat. § 244.120(a), an appointed public official serving on a board must announce the nature of a potential conflict "prior to taking any official action thereon." The statute neither suggests the requirement to nor compels recusal from participation in discussion.¹⁷ Or. Rev. Stat. § 677.208.

Nor does the asserted failure of the BOME to comply with a procedural requirement of the Oregon statute strip its actions of the state action immunity. As Professor Areeda explained:

"* * *. Of course, state law 'authorizes' only agency

¹⁷While the language of the statute may arguably conflict with Campbell v. Board of Medical Examiners, 16 Or. App. 381, 395, 518 P.2d 1042 (Or. App. 1974), proper procedure for resolving this nicety of state law is available through judicial review. Furthermore, Or. Rev. Stat. § 244.120(a) was enacted after the decision in Campbell and thus the case has no continuing vitality. 1974 Oregon Laws (Special Session), C. 78 § 10.

decisions that are substantively and procedurally correct. Errors of fact, law, or judgment by the agency are not 'authorized', and state tribunals will normally reverse erroneous acts or decisions. If the antitrust court demands unqualified 'authority' in this sense, it will inevitably become the standard reviewer of government agencies whenever it is alleged that the agency, though possessing the power to engage in the challenged conduct, has exercised its power erroneously. * * *."

Areeda, "Antitrust Immunity for 'State Action' After Lafayette," 95 Harv. L. Rev. 435, 449-450 (1981).

As Judge Kennedy stated:

"At the outset, we should note that even the constitutional invalidity of the attempted state regulation is not an appropriate basis for disregarding the immunity conferred by Parker. Preferred Communications, Inc. v. City of Los Angeles, 754 F.2d 1396, 1414 (9th Cir. 1985). Accord, Bates v. State Bar of Arizona, 433 U.S. 350, 97 S. Ct. 2691, 53 L.Ed.2d 810 (1977). From this, it should follow that a procedural irregularity in the adoption of the challenged state

regulation does not render Parker inapplicable."¹⁸

Finally, petitioner argues, ingenuously, that even if Dr. Russell were immune, that it does not follow that others who participated as complainants or witnesses before the BOME should be (see Pet. Br. at 44). In positing this argument, petitioner relies on the doctrine of judicial immunity, as distinguished from the state action doctrine, and emphasizes that "judicial immunity" does not extend to litigants or witnesses. Judicial immunity generally does not extend to private parties. Dennis v. Sparks, 449 U.S. 24, 27, 31-32 (1980). However, no decided authority suggests that those who participate in a state-mandated process as proponents, advocates, witnesses or

¹⁸Llewellyn v. Crothers, 765 F.2d 769, 774 (9th Cir. 1985).

complainants are deprived of state action immunity. Indeed, Southern Motor Carrier Rate Conference, Inc. v. United States, 471 U.S. 48, 56, 57 (1985), counsels precisely to the contrary.¹⁹

To hold otherwise is, again, to subject Oregon's policy of encouraging a free flow of information to the BOME to restraints. Comity counts against such fine distinctions in liability.

¹⁹It is respectfully urged that private parties who appear as witnesses or who make complaint to the BOME need not demonstrate the "active supervision" component of the state action doctrine. Even if such requirement were imposed, the BOME's statutory scheme is clearly satisfactory.

Furthermore, respondents contended before the Ninth Circuit and here that the actions of complainants and witnesses in testifying before the BOME is immune from liability under United Mine Workers of America v. Pennington, 381 U.S. 657 (1965), and Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961), and constitute a separate ground for affirmance of the Ninth Circuit decision.

c. Evidence of BOME Proceedings Is Inadmissible under Fed. R. Evid. 501.

Fed. R. Evid. 501 provides that:

i. Claims based on an act of Congress shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience; and

ii. If state law applies the rule of decision, it shall be determined in accordance with state law.

Under Fed. R. Evid. 501, in diversity cases, state law concepts of privilege control. Samuelson v. Susen, 576 F.2d 546, 549-550 (3d Cir. 1978). Cases based solely upon an act of Congress are governed by federal concepts of privilege. In re Pebsworth, 705 F.2d 261 (7th Cir. 1983).

The federalist tension is evident. As a matter of comity, when particular evidence is protected by a state statutory privilege which encourages disclosures to protect the public, should a Federal Court in an action under federal law fashion a "common law privilege" coincident with that existent under state law?

In United States v. Allery, 526 F.2d 1362, 1365 (8th Cir. 1975), the Eighth Circuit stated:

"Federal courts may, however, look to the privileges created by state courts and applicable state statutes if the court finds them appropriate within the guidelines set forth in Federal Rule of Criminal Procedure 26 and Federal Rule of Evidence 501. * * *."

Congress did not intend, in the enactment of Fed. R. Evid. 501, to freeze the law of privilege. Instead, the rule is to "provide the courts with the flexibility to develop rules of privilege on a

case-by-case basis and leave the door open to change." Trammel v. U.S., 445 U.S. 40, 47-48 (1980).

Courts differ regarding the recognition of a federal common law privilege barring the introduction of evidence of professional regulatory proceedings.²⁰

The lead case of Bredice cogently recognized the need for such privilege:

"* * *. Candid and conscientious evaluation of clinical practices is a sine qua non of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity,

²⁰Compare Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (1970), aff'd., 479 F.2d 920 (D.C. Cir. 1973); Mewborn v. Heckler, 101 F.R.D. 691, 693 (D. D.C. 1984); Mennes v. South Chicago Community Hospital, 427 N.E.2d 952 (Ill. 1981); Murphy v. Wood, 667 P.2d 859 (1983); (all recognizing privilege) with, Memorial Hospital for McHenry County, v. Shadur, 664 F.2d 1058 (7th Cir. 1981); Robinson v. Magovern, 83 F.R.D. 79 (W.D. Pa. 1979) (rejecting privilege).

would result in terminating such deliberations. * * *."

The federal courts have adopted the four-step analysis for determination of the existence of a federal common law privilege:

- o The communication was made with the understanding it would not be disclosed.

- o The element of confidentiality must be essential to the full maintenance of the relationship.

- o The relationship is one which ought to be sedulously fostered; and

- o The injury that would inure to the relation by the disclosure of the communication must be greater than the benefit that would result from requiring disclosure. Witten v. A.H. Smith & Co., 100 F.R.D. 446 (1984). J. Wigmore, Evidence In Trials At Common Law, § 2285, p. 557 (3rd. Ed. 1940, rev. 1970).

Here, petitioner seriously disputes only the fourth factor. However, the hardship/benefit balance must be struck against disclosure for two reasons.

First, preservation of the system of peer review in the Hospital and before the BOME transcends the need for proof in any individual case. Once confidentiality is breached, the injury to the system of peer review is irremediable. The benefits of confidentiality -- five-fold increase in complaints to BOME after confidentiality was guaranteed by statute -- will be lost. The public will suffer from erosion of the peer review process (Tr. 743).

Second, neither hospital proceedings nor the BOME proceedings are free from state law scrutiny. Supra, p. 40-41; Or. Rev. Stat. § 677.708. Given the concomitant needs to safeguard confidentiality and the protections of

judicial administration review afforded under state law, the fourth factor mandates recognition of the privilege.

Fed. R. Evid. 501, federal common law, and considerations of the principles of comity compel recognition of a privilege barring admission of evidence of the BOME proceedings and of hospital based peer review.

CONCLUSION

The Judgment of the Court of Appeals should be affirmed.

Respectfully submitted,
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APPENDIX

41.675 Inadmissibility of certain health care facility and training data.

(1) As used in subsection (2) of this section "data" means written reports, notes or records of tissue committees, governing bodies or committees of a health care facility licensed under ORS chapter 441, medical staff committees and similar committees of professional societies in connection with training, supervision or discipline of physicians, or in connection with the grant, denial, restriction or termination of clinical privileges at a health care facility. The term also includes the written reports, notes or records of utilization review and professional standards review organizations.

(2) All data shall be privileged and shall not be admissible in evidence in any

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judicial proceeding, but this section shall not affect the admissibility in evidence of a party's medical records dealing with a party's hospital care and treatment.

(3) A person serving on or communicating information to any governing body or committee described in subsection (1) of this section shall not be examined as to any communication to that committee or the findings thereof.

(4) A person serving on or communicating information to any governing body or committee described in subsection (1) of this section shall not be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

(5) Subsection (2) of this section shall not apply to judicial proceedings in which a health care practitioner contests the denial, restriction or termination of

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clinical privileges by a health care facility. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding. [1963 c. 181 § 1; 1971 c. 412 § 1; 1975 c. 796 § 1; 1977 c. 448 § 9; 1981 c. 806 § 1]

REPLY

BRIEF

17
No. 86-1145

Supreme Court, U.S.

FILED

FEB 8 1988

JOSEPH F. SPANGL, JR.
CLERK

In The
Supreme Court of the United States

October Term, 1987

— o —
TIMOTHY A. PATRICK, M.D.,

Petitioner,

v.

WILLIAM M. BURGET, M.D., JEFFREY M. LEINASSAR, AS PERSONAL REPRESENTATIVE OF JORMA M. LEINASSAR, M.D., DECEASED, R.G. KETTLEKAMP, M.D., PATRICK MEYER, M.D., GARY M. BOELLING, M.D., ROBERT D. NEIKES, M.D., FRANKLIN D. RUSSELL, M.D., LEIGH C. DOLIN, M.D., RICHARD C. HARRIS, M.D., DANIEL M. RAPPA-PORT, M.D., and TZU SUNG CHIANG, M.D., DOING BUSINESS AS ASTORIA CLINIC,

Respondents.

— o —
**On Petition for Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit**

— o —
REPLY BRIEF OF PETITIONER
— o —

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I. REPLY TO STATEMENT OF FACTS¹

Is the statement of facts in defendants' brief reliable? Consider the following two examples.

Did Dr. Russell recuse himself from participating? In our opening brief, we said that after Dr. Russell publicly announced a conflict of interest and disqualified himself from taking part in the Board of Medical Examiners proceedings, he then nevertheless played a leading role in secret. Compare what defendants have told this Court about this episode with the official records of the Board:

WHAT DEFENDANTS SAY

"Consequently, Dr. Russell recused himself from voting but not from participation in deliberations." (Def.Br. 4.)

WHAT THE RECORD SHOWS

"Dr. Russell removed himself from discussion due to conflict of interest." Ex. 38, p. 5, rec'd at Tr. 1024.)

The words on the right are the opposite of the words on the left, and have no support in the record.²

Did Dr. Patrick say his only mistake was in getting caught? Defendants say he made that statement at a Hospital Executive Committee meeting. (Def.Br. 15 n. 2; Tr. 2517-18.) What they don't say is that the Executive Committee tape recorded this particular meeting, and the transcript of the tape shows he never said anything remotely like that. (Ex. 1292, rec'd at Tr. 729-30.)

¹In our opening brief, there is a typographical error on page 13. The reference to Tr. 8433 should read Tr. 843.

²Neither is there any evidence that Dr. Russell declared only a limited disqualification at the Investigative Committee meeting a few days before. (Tr. 261; cf. Tr. 744-46.)

What is even more surprising is that this is the third time defendants have included this accusation in a brief, once on appeal to the Ninth Circuit and once in opposing our petition for certiorari. Each time we pointed out in our reply that the accusation was demonstrably false, for the reason stated. That has not deterred them from making it again.

Defendants also are obligated to state the facts in the light most favorable to Dr. Patrick. Instead, they have done just the opposite. Their statement of facts is nothing but a shorter version of their unsuccessful jury argument to the effect that they acted properly with the best of motives to discipline an inadequate surgeon. Here are a few examples.

(1) When they discuss the testimony of Dr. Patrick's expert witness,³ they refer *only* to his cross-examination, never to his direct testimony. (Def.Br. 16-17.) That is not the way to present the evidence most favorable to plaintiff.⁴

(2) On the other hand, when they discuss the testimony of their own expert witness, Dr. Alberty (Def.Br. 17-18.), they refer *only* to his direct testimony, never to his cross-examination (*q.v.*, Tr. 2279 *et seq.*) Neither is

³Dr. Warrington, whose name defendants misspell as "Warrenton". (Def.Br. 16.)

⁴By contrast, compare Dr. Warrington's direct testimony about the Patterson case at Tr. 780; the Bode, Kemmer and Nygren cases at Tr. 771-72, 774-77, 772-74 (and see our opening brief at 28-29); the Broderick case at Tr. 778-79; the Snodgrass case at Tr. 785-86. As for the Partridge case, the testimony which they attribute to Dr. Warrington is not what he said. Cf. Tr. 783-85, 806-09.

that the way to present the evidence most favorable to plaintiff.

(3) They single out the negative aspects of Dr. Battalia's letter, particularly the accusation of patient "abandonment"—i.e. leaving a patient in the care of a physician who is not a surgeon. (Def.Br. 7-8.) They leave out that they were responsible for this being the standard practice in Astoria, and that their own surgeon, defendant Dr. Harris, did the same or worse. (Tr. 351-52, 858-59; Pl.Br. 10-11, 16-17.)

(4) They suggest Dr. Patrick could have had an adequate remedy by appealing any adverse decision of the *ad hoc* committee to the Hospital's Board of Trustees, citing certain evidence. (Def.Br. 18-19.) They don't mention the evidence that: (a) two of the Board members were defendants Dolin and Kettlekamp, members of the Astoria Clinic, both of whom had already voted as members of the Executive Committee to revoke his privileges (Tr. 365; Ex. 1292, rec'd at Tr. 729-39); (b) a third Board member was the father of one of the Astoria Clinic physicians (Tr. 365, 1208); (c) the defendant Dr. Boelling had himself been on the Board until shortly before he became chairman of the *ad hoc* committee (Tr. 1154); (d) most of the Board members were patients of the defendants (Tr. 365, 1205-09); (e) one long-term member of the Board testified that the Board had to rely on the recommendations of the medical staff when it came to privilege decisions, and that in his ten years on the Board he couldn't remember the Board ever rejecting a recommendation of the staff (Tr. 2189-92); (f) the Hospital Administrator gingerly volunteered the term "rubber-stamp" to describe the relationship of the Trustees to the staff. (Tr. 1363.)

II. THE JURY FOUND THAT DEFENDANTS ACTED WITH AN ANTICOMPETITIVE INTENT.

Defendants complain of an instruction which they say allowed the jury to find a restraint of trade even if defendants' motive were proper. (Def.Br. 19-20.) The instruction as given reflects established law. *See, e.g., McLain v. Real Estate Board of New Orleans, Inc.*, 444 U.S. 232, 243, 100 S.Ct. 502, 509, 62 L.Ed.2d 441 (1980). It was taken from "Antitrust Civil Jury Instructions," Section of Antitrust Law, American Bar Association (1980), p. 104. It should also be viewed in the context of the other instructions on the § 1 claim, taken as a whole. *See, e.g.,* Tr. 2905-06, 2914-15, 2916-18.

Even if this instruction were error, it is harmless. There were two antitrust claims submitted to the jury, one for violation of § 1 of the Sherman Act, the other for violation of § 2. This instruction which they attack applied only to § 1, not § 2. (Tr. 2906, 2917; *cf.* Tr. 2919-25.) The jury verdict on the § 2 claim was against the entire Astoria Clinic⁵, and was not affected by this instruction, for the jury was instructed that legitimate motive was a complete defense. (Tr. 2920-23; J.A. 45.)

As for the § 1 claim which was supposedly tainted by this instruction, the verdict was only against three defendants: Drs. Russell, Boelling, and Harris—the three defendants who figure most prominently in these events. (J.A. 45.) The jury also found these same three defen-

⁵The expression "Astoria Clinic" was used as shorthand by both sides for all defendants, who were partners "doing business as Astoria Clinic." (*See, e.g.,* caption of all briefs; Ex. 3 rec'd at Tr. 139; Tr. 2762, 2764, 2768-69, 2797; CR 166, 182.)

dants, and only these three defendants, liable for punitive damages on the state law claim. (J.A. 45-46) This meant they found these three to be guilty of "wanton misconduct", and that they acted in bad faith. (Tr. 2929-31, 2932, 2933-34.) The jury apparently applied an even stricter standard to the § 1 claim than to the § 2 claim.

III. THE DISTRICT COURT HAD JURISDICTION OVER THESE CLAIMS.

Defendants casually question federal jurisdiction in passing, without telling the court why they think it doesn't exist. (Def.Br. 32 n. 6.) Yet there was adequate evidence of interstate commerce.

The most obvious is that Astoria is a border city. Both the Astoria Clinic and the Hospital drew significant numbers of patients from Washington. (Tr. 148-49, 1267-75, 1298; Ex. 100 rec'd at Tr. 1274; Ex. 134 rec'd at Tr. 109.) The Hospital earned over \$400,000 per month from Washington patients. (*Id.*; Tr. 1274.)

Before Dr. Patrick lost his privileges, his overall practice was earning \$357,000 per year. (Ex. 85 rec'd at Tr. 2001.) From Washington he drew 15 to 20 percent of all his patients, and 50 percent of his higher-fee vascular surgery patients. (Tr. 223-24, 369, 1271.) All of these Washington vascular surgery patients are gone, since CMH (the Hospital in Astoria) is the only place where he could perform it. (Tr. 223, 360; Ex. 85 rec'd at Tr. 2001.) There is no more thoracic or vascular surgery performed at CMH. (Tr. 1335-36.) It has had to reduce its budget because of his loss of privileges. (Tr. 1291.) Washington doctors who referred patients to Dr. Patrick do not nec-

essarily refer patients to other Astoria doctors. (Tr. 1591-92.) Most of the surgery which Dr. Patrick still performs is now done in Washington instead of Oregon. (Tr. 359, 360.)

There was other evidence of interstate commerce. All pharmaceuticals at CMH are manufactured or purchased out of state. (Tr. 1328-29.) It receives substantial payments from Medicare and insurers. (Tr. 1275-76, 1279.) Its employees are from both states. (Tr. 1273.)

IV. THE STATE ACTION DOCTRINE DOES NOT SHELTER DEFENDANTS' CONDUCT.

A. There was no clearly expressed state policy permitting defendants to conspire or attempt to monopolize.

In our opening brief, we analyzed the market by distinguishing between physicians and hospitals. We said that there is nothing inherently anticompetitive about a hospital exercising care in granting hospital privileges to physicians, even if it is other physicians who make those decisions on behalf of the hospital. If a hospital imposes high standards on purveyors of food or medicine who compete for sales to the hospital, it does not in any way restrict competition among those purveyors for the hospital to reject those who are below its standards. If anything, it sharpens competition among them. Particular competitors may suffer when the market disciplines them for their inadequacies, but competition thrives on it. It is of course the latter and not the former which the anti-trust laws protect.

The same reasoning applies to physicians who compete for access to hospital privileges. There is nothing

anticompetitive about it so long as the physicians who make the privilege decisions on behalf of the hospital make them in good faith, for professional reasons, and for the purposes expressed in the statute. It only becomes anticompetitive when they make these decisions for anti-competitive reasons.

The Court will observe that neither defendants nor *amici* have attempted to answer this argument. They all evade it. None of them offer an alternative precise analysis of the market. They all hide in generalities which obscure the realities. They make the error of assuming that it is anticompetitive for a hospital to reject a particular physician on account of his inadequacies. (See, e.g., Def. Br. at 36.)

It is true that the State of Oregon licenses hospitals and regulates them in various ways. (See Def.Br. at 34.) It by no means follows that the state thereby authorizes anticompetitive exclusionary conduct by physicians. Furthermore, the simple fact of regulation does not in itself give an industry carte blanche to engage in exclusionary conduct. For example, this Court once observed that although states regulate the insurance business, no states authorized "combinations of insurance companies to coerce, intimidate and boycott competitors and consumers in the manner here alleged." *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533, 562 (1944). In another case in which the Canadian government had deputized a private company to act as its purchasing agent and gave it broad regulatory authority, this Court nevertheless noted there was no indication that any part of the Canadian government "approved or would have approved of joint

efforts to monopolize the production and sale of vanadium or directed that purchases from Continental be stopped." *Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 706 (1962).

In previous state action cases, this Court has recognized that a general authorization by a state to act is not in itself necessarily equivalent to state authorization of particular conduct. For example, this Court once considered Louisiana state laws which authorized cities to operate electrical utilities, but concluded that they were insufficient to authorize a city "to act as it did", i.e. to engage in exclusionary conduct. *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978). See also *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 790-92 (1975).

It is even clearer in this case that the state has not authorized this particular conduct. Not only has Oregon *not* authorized attempts to monopolize through peer review: it has enacted a statute that disapproves of peer review conducted in bad faith, i.e., for purposes other than those specified in the statute.⁶ The Court will observe that neither defendants nor any of the *amici* have found anything to say about this statute. They do not even mention the statute. They made no answer to the argument we based on it. The Court may infer they have no answer to make.

What they do instead is to make policy arguments why this Court should disallow "case-by-case" analysis of

⁶Or. Rev. Stat. § 41.675(4). Incidentally, this peer review was conducted under Hospital bylaws which themselves contemplate immunity from liability for peer review only if it was done in "good faith". (Ex. 156 page 30, rec'd at Tr. 304.)

peer review decisions. (Def.Br. 37.) Yet case-by-case analysis is precisely what is contemplated by the statute which extends immunity only when the peer review was in good faith.⁷

This statute also distinguishes two cases on which defendants rely. *Hoover v. Ronwin*, 466 U.S. 558 (1984); *Llewellyn v. Crothers*, 765 F.2d 769, 774 (9th Cir. 1985). A further distinction is that the conduct being examined was that of state officers carrying out state policy, not private individuals. What those state officers did was within the scope of their authority. Unlike our case, there was no motive to destroy competition to further private interests. One should not confuse the legal consequences of a personal prejudice and a specific intent to monopolize a private market.

B. There was no active supervision.

The Solicitor General addressed this issue in his brief. We adopt his argument at pages 7-18.

(1) *The Health Department does not actively supervise peer review.* Defendants rely heavily on the fact that hospitals are licensed. That is irrelevant. We demonstrated why on pages 40-41 of our opening brief. They have avoided the argument we made there. They apparently have no reply.

Any number of examples illustrates why licensing has little to do with state action. We attorneys hold licenses

⁷So also for the federal statute which makes immunity from antitrust liability depend upon whether the peer review action was taken "in the reasonable belief that [it] was in the furtherance of quality health care." 42 U.S.C. § 11112(a).

from the State of Oregon to practice law. Oregon statutes and regulations impose various duties upon us as attorneys. For example, Disciplinary Rule 6-101 requires: "A lawyer shall provide competent representation to a client." If someone should complain that we violated this duty, the Oregon State Bar and the Oregon Supreme Court could discipline us, even revoke our license. Yet none of this means that our practicing law is state action.

Consider another example. If a citizen is injured by another's violation of law, he may complain to the District Attorney. The District Attorney has a duty to pursue any complaint by a citizen where there has been a violation of law. Or. Rev. Stat. § 8.665. That does not mean that the State of Oregon is engaged in the active supervision of burglaries or other violations of law.

The distinction which these examples illustrate is this: if there is *any* supervision by Oregon over peer review, which we doubt, it is at most *passive* supervision, not active. We also note that there is no evidence in this record that the Health Division has ever done anything about peer review, either in this case or in any other.

Finally, as both we and the Solicitor General have pointed out, the only law related to peer review which the Health Division has any authority to enforce is the law which requires *hospitals* to have procedures in place for peer review. This hospital did have procedures in place. There may very well have been no violation of that law. The law which was violated was the Sherman Act, and that is not a statute which has been given to the Health Division to enforce.

(2) *The Board of Medical Examiners does not actively supervise peer review.* Defendants appear to concede that the Board does not have the authority to reverse peer review decisions. (Def.Br. 44.) Defendants do mislead, however, by suggesting that the Board "reviews" such decisions. (Def.Br. 44.) That is not what the statute says. Or. Rev. Stat. § 441.820(1). All the Board can do is investigate whether it should do something about the affected physician's license to practice medicine.

(3) *The possible availability of private remedies in state court is not active supervision by the state.* Defendants have not answered the arguments made by us and by the Solicitor General.

V. THE EVIDENCE OF THE PROCEEDINGS OF THE BOARD OF MEDICAL EXAMINERS WAS ADMISSIBLE.

Defendants complain about the admission of certain evidence from the records of the Board of Medical Examiners. Errors in the admission of evidence are not reversible if they were harmless. Defendants do not identify precisely what evidence they refer to, nor where in the record any objections were raised and overruled,⁸ nor do they explain why the evidence was harmful to them. We infer, however, that they complain because we discovered the surreptitious and duplicitous behavior of Dr. Russell on the Board of Medical Examiners. We also infer that

⁸This makes it almost as difficult for us to respond to the argument as it does for the Court. For example, our recollection is that evidence of what went on in secret Board proceedings was first obtained in the separate civil rights action against the Board. We cannot tell whether the evidence which defendants here complain about was evidence which was obtained pursuant to an order obtained in this proceeding.

they complain that we discovered that the chairman of the *ad hoc* committee reviewing Dr. Patrick's privileges—Dr. Boelling—had already testified in secret against him about three of the cases he was judging.

They argue that the law should have kept all this hidden both from Dr. Patrick and from the jury. This is not even in accord with state law, let alone federal law.

A. State law did not prohibit the admission of this evidence.

Defendants do not cite any state statute affecting the admissibility of the evidence of the conduct of Dr. Russell. They only cite a statute which declares that information provided by others to the Board is confidential. Or. Rev. Stat. § 677.425(1). That Dr. Boelling had complained to the Board was established by his direct testimony at trial, without apparent objection, as far as we can tell. (Tr. 1157.)

Defendants also leave out subsection (2) of this same statute:

“(2) Any person who reports or provides information to the board * * * and who provides information *in good faith* shall not be subject to an action for civil damages as a result thereof.” (Emphasis added.)

This statute clearly contemplates that a person who provides information to the board in bad faith shall be answerable in a civil action. We submit that the purpose of subsection (1) was to protect the information against use in subsequent malpractice actions.

B. The evidence was properly admitted under controlling federal law.

State privilege law is not controlling in a federal action founded on federal question jurisdiction. Fed. R. Evid. 501. See, e.g., *Wm. T. Thompson Co. v. General Nutrition Corp., Inc.*, 671 F.2d 100, 103 (3d Cir. 1982); *Memorial Hospital for McHenry County v. Shadur*, 664 F.2d 1058, 1061 (7th Cir. 1981); *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530, 544 n. 9 (5th Cir. 1978). Under Fed. R. Evid. 501, the existence of a privilege in a federal action is “governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.”

Evidentiary privileges exclude relevant information from the trier of fact and are strongly disfavored in federal practice. See, e.g., *Herbert v. Lando*, 441 U.S. 153, 175 (1979); *United States v. Nixon*, 418 U.S. 683, 709-10 (1974).

Defendants' arguments have been rejected in medical antitrust cases. In *Shadur, supra*, the court held that the public interest in private enforcement of federal antitrust laws was too strong to permit the exclusion of relevant and crucial evidence by application of a state law privilege.

Defendants rely on *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973), as support for the proposition that state privilege law should be adopted as the federal common law in this area. The vitality of *Bredice* has been questioned in light of *United States v. Nixon, supra*. It was soundly criticized in *Robinson v. Magovern*, 83 F.R.D. 79, 86, 87, 88, 89 (W.D. Pa. 1979), where the court refused to apply its rationale.

Bredice was also a malpractice case where the plaintiff sought to discuss minutes and reports of hospital boards reviewing the death. The court was concerned that constructive criticism would be used in a malpractice suit. *Mewborn v. Heckler*, 101 F.R.D. 691 (D.D.C. 1984), on which defendants also rely, was also a malpractice action.

Our case, like *Shadur*, *Wm. T. Thompson Co.*, and *Magovern*, *supra*, is an antitrust action, not medical malpractice. What happened in the Board of Medical Examiners proceeding is part of the evidence of what happened to Dr. Patrick. That distinguishes it from malpractice actions, in which a party only wants to discover what someone else may have thought about the issues to be tried.

C. The state action doctrine does not bar the use of this evidence.

Defendants complain that we did not argue in the District Court that the evidence should be admitted as evidence of a continuing conspiracy. (Def.Br. 55.) It is impossible for us to respond to this argument since defendants do not tell us precisely what evidence it is they are objecting to, nor where in the record an objection was made to the trial judge, nor where ruled upon. In any event, there can be no error if the evidence was properly admitted for a different reason.

(1) *Dr. Russell had no authority to act after he disqualified himself.* As we demonstrated earlier, Dr. Russell did not announce a *potential* conflict of interest, reserving the right to continue to act. He announced a conflict of interest and disqualified himself without limitation. The statute on which defendants rely is inapplicable. (Def.

Br. 62.) That statute applies when a public official is uncertain whether he or she has a real conflict of interest. Or. Rev. Stat. § 244.120. It provides to the official and to the public a middle course of action: the official discloses the potential conflict and then continues to act. It does not apply when an official actually removes himself or herself from participating in the matter. After that, the public official has no authority whatsoever to act in the matter. That statute was clarified by the amendment of Or. Rev. Stat. § 244.120 in 1975, in which the word "potential" was added. (1975 Or. Laws Ch. 543 § 10.) The principle that a disqualified official has no authority to act was applied five years later. *Boughan v. Board of Engineering Examiners*, 46 Or. App. 287, 291, 611 P.2d 670, 672 (1980). What Dr. Russell did was therefore without authority from the State of Oregon, therefore not state action. It was a sham, meriting a sham exception to the state action doctrine, just as there is a sham exception to the *Noerr-Pennington* doctrine. We sufficiently raised this point in our Petition for Certiorari. (Questions presented, and at page 19.)

Furthermore, one should bear in mind that the punishment of Dr. Patrick without adequate notice and hearing violated his constitutional right to due process. It is not seemly that the evidence of that should be suppressed.

(2) *Dr. Patrick did not claim that his revenues were diminished by action of the Board of Medical Examiners.* Defendants misrepresent Dr. Patrick's evidence of damages. (Def.Br. 55.) The Board's reprimand letter was issued in April 1980. (Ex. 51 rec'd at Tr. 262-63.) For Dr. Patrick's fiscal year which ended 10 months later,

he had the largest income in his career. (Tr. 1553-54.) Dr. Patrick's expert attributed the various changes in his income at this time and thereafter to the recession, to the loss of his associate Dr. Weber, and to his loss of privileges at the hospital.⁹ (Tr. 1520-21.) No witness attributed any loss of income to the Board of Medical Examiners proceeding.¹⁰

VI. THE SHERMAN ACT DID NOT REQUIRE DR. PATRICK TO ENDURE THE AD HOC COMMITTEE PROCEEDING TO THE END.

The Executive Committee had already voted to revoke Dr. Patrick's privileges. As we pointed out before, during the hearing which followed Dr. Patrick despaired of receiving a fair hearing or review, and resigned for practical reasons. Now, defendants say that his judgment must fall because of a supposed failure to exhaust the hearing process at the Hospital.

Bear in mind that the supposed "administrative remedy" was at the Hospital. The Hospital was an organ neither of the federal government nor of the state government. Indeed, it was a co-conspirator in this case and a

⁹At two places the witness refers imprecisely to a decrease "from 80 to 81." (Tr. 1522, 1525.) He apparently is referring to the decrease beginning in 1981, since that was the first decrease. (Tr. 1520.)

¹⁰At the worst, even if it were held that the judgment might have included evidence of lost income prior to the loss of privileges, and thereby might indirectly have included damages somehow attributable to the Board proceedings, the amount of damages conceivably attributable to that period was less than \$134,666. (Tr. 1530.) The maximum relief available to defendants should be a remittitur, the amount of which the District Court could decide.

defendant. It shared the responsibility for the facts of this case and for the tainted proceedings. The question whether Dr. Patrick could have avoided damages by not resigning was put to the jury, and it evidently decided that he could not have. (Tr. 2928, 2931.)

This is, after all, a federal antitrust case for damages. There is no principle which subordinates the national policy condemning anticompetitive conduct to a private pseudo-administrative process. There are no cases cited by defendants which require exhaustion of any kind in federal antitrust actions for damages.

Neither is there a general rule requiring exhaustion in every instance. Davis, 4 *Administrative Law Treatise*, § 26:15 (2d ed. 1983). Even where exhaustion applies, it is subject to numerous exceptions. See *McKart v. United States*, 395 U.S. 185, 193 (1969).

Exhaustion is not required when internal remedies are unavailable, inadequate or futile. *Garrow v. Elizabeth General Hospital*, 79 N.J. 549, 402 A.2d 533, 539 (1979). Neither is it required when it would cause irreparable injury, as Dr. Patrick testified it would. *Id.*, 401 A.2d at 539. Exhaustion is not required when there is a well-supported charge of bias against the administrative body. *Gibson v. Berryhill*, 411 U.S. 564, 578-79 (1973).

The Seventh Circuit has held exhaustion not required when the only remedy sought was damages, not reinstatement. *Qasem v. Kozarek*, 716 F.2d 1172, 1175 (7th Cir. 1983). The same is true here.

Finally, when exhaustion is not a statutory jurisdictional concept, its application is subject to the discretion

of the trial court. *NLRB v. Industrial Union of Marine and Shipbuilding Workers Local 22*, 391 U.S. 418, 426 n. 8 (1968); *State of Missouri v. Bowen*, 813 F.2d 864, 871 (8th Cir. 1987); Davis, *supra*, § 26:1. The trial court's exercise of discretion in this matter will not be disturbed but for clear abuse of discretion. *Dale v. Chicago Tribune Co.*, 797 F.2d 458, 466 (7th Cir. 1986), *cert. denied* 107 S.Ct. 954 (1987); *Medina v. Castillo*, 627 F.2d 972, 975 (9th Cir. 1980).

o

CONCLUSION

This Court should reverse the judgment of the Court of Appeals.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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In the Supreme Court of the United States

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, PETITIONER

v.

WILLIAM M. BURGET, ET AL.

**ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONER**

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24/10/87

QUESTION PRESENTED

The United States will discuss the following question:

Whether the State of Oregon engages in "active supervision" of the decisions of hospital peer review committees to terminate doctors' staff privileges, as is required in order for the state action doctrine to bar a terminated doctor's antitrust lawsuit against members of the peer review committee and their alleged co-conspirators.

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AS AMICUS CURIAE SUPPORTING PETITIONER**

INTEREST OF THE UNITED STATES

The United States has primary responsibility for enforcement of the federal antitrust laws and therefore has a substantial interest in assuring that those laws are construed in a manner that advances their objectives. At the Court's invitation, the United States filed a brief at the petition stage of this case.

STATEMENT

1. Petitioner is a surgeon practicing in Astoria, Oregon. Astoria has only one hospital, Columbia Memorial Hospital (CMH). Respondents are physicians who at all relevant times were partners in the Astoria Clinic. A majority of the staff members at CMH were employees or partners of the Astoria Clinic. In 1973, after expiration of a one-year contract with the Astoria Clinic, petitioner declined an invitation to join the Clinic and instead began an independent practice in competition with surgeons at the Clinic. Pet. App. 2a-3a.

In late 1979, respondent Boelling, a Clinic physician, complained to the hospital medical staff about an incident in which Boelling said that one of petitioner's patients was left in the care of another physician, who then left the patient unattended (Pet. App. 4a-5a). Boelling's complaint, along with complaints about other cases allegedly handled by petitioner, was referred to the state Board of Medical Examiners (BOME), whose three-member investigative committee was chaired by respondent Russell, another Clinic physician (*id.* at 5a). The BOME issued a letter of reprimand but retracted it after petitioner sought judicial review (*id.* at 5a-6a).

In November 1981, at the request of respondent Harris, another Clinic physician, the peer review committee at CMH began proceedings to terminate petitioner's hospital privileges (Pet. App. 7a). The chairman of the committee was respondent Boelling, who earlier had complained about petitioner to the BOME and, in that forum, had testified against petitioner concerning some of the cases that were now before the committee. Petitioner requested that members of the committee testify on the subject of their personal bias against him, but they refused; during his presentation at the peer review hearing, the committee allegedly was inattentive. Eventually, petitioner resigned from the hospital staff rather than risk termination. *Id.* at 7a-8a.¹

2. Petitioner sued the Astoria Clinic and its physicians. Petitioner claimed violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. 1 and 2. Petitioner also claimed that respondents were liable under state law for the tort of interference with prospective economic advan-

¹ The court of appeals did not address any issues raised by petitioner's decision to resign before termination of his privileges (Pet. App. 14a n.7), and respondents have not pursued the point in this Court.

tage. Pet. App. 2a, 8a, 16a n.13.² Petitioner contended that respondents' primary motive in conducting peer review was to reduce or eliminate competition from petitioner rather than to improve patient care. Respondents vigorously denied this, and the factual dispute was submitted to the jury.³

² An additional count of the complaint charged respondents with violation of state antitrust laws (Or. Rev. Stat. §§ 646.725, 646.730 (1985)), but that count was not submitted to the jury.

³ The jury was instructed, among other things, that respondents and their alleged co-conspirators "had the right to refuse to deal with [petitioner] for any reason, good or bad, so long as they did so as a result of their own business judgment and not as a result of or in pursuance of any conspiracy" (Tr. 2915); that "[s]uch conduct of [respondents] which [the jury found] to have been primarily motivated by legitimate business * * * or professional objectives, such as [respondents'] alleged concern for proper patient care and interpersonal relationships between members of the staff, is not anti-competitive in purpose" (Tr. 2918); that, if the jury found that respondents' conduct "was predominantly motivated by legitimate business or professional aims and not by a specific intent to injure or destroy competition, [it] must find in favor of [respondents] on [petitioner's] conspiracy and attempt to monopolize claim" (Tr. 2922); that "if [respondents'] practices were motivated by concerns over provision of health care to the community and are of the type which would govern reasonable persons confronted with the same or similar circumstances, then [the jury] should find that [respondents] did not have the specific intent to monopolize the market for surgical services" (Tr. 2922-2923); that, if the jury found that respondents "in initiating proceedings before the Columbia Medical Hospital Ad Hoc Committee acted in good faith and without malice, * * * their actions and conduct are immune from liability and their conduct may not be considered as evidence of any unlawful conspiracy or attempt to monopolize or in connection with claims of wrongful interference with staff privilege[s]" (Tr. 2932); and that the jury could award punitive damages on petitioner's claim under state tort law only if it first determined that respondents "were guilty of wanton misconduct which was a cause of damage to" petitioner (Tr. 2934).

The jury found against certain respondents on the Section 1 claim, the Section 2 claim, and the tort claim and also found that punitive damages should be awarded on the tort claim. It awarded damages of \$650,000 on petitioner's two antitrust claims taken together. The court, as required by law (15 U.S.C. 15), trebled the antitrust damages. The jury awarded petitioner an additional \$20,000 compensatory and \$90,000 punitive damages for tortious interference with prospective economic advantage. Pet. App. 8a.

3. The court of appeals reversed. It found that there was substantial evidence that the respondents had acted in bad faith (Pet. App. 9a, 12a-13a).⁴ Nonetheless, it ruled that, even if respondents had misused the hospital peer review process to disadvantage a competitor rather than to improve patient care, respondents' conduct was "state action" immune under the two-part test articulated in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980), and applied to private conduct in *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 57 (1985). Under that test, private conduct is deemed state action and immune from challenge under the antitrust laws if (1) the private conduct is undertaken pursuant to a clearly articulated state policy to displace competition, and (2) there is active supervision of the private conduct by the state.

The court of appeals concluded first that the State had clearly articulated a policy to limit competition because "Oregon, by compelling physicians to review their competitors, affirmatively has expressed a policy to replace pure competition with some regulation" (Pet. App. 10a

⁴ Viewing the evidence in the light most favorable to petitioner (as it was required to do because the jury had returned general verdicts in favor of petitioner on each of his claims), the court of appeals characterized respondents' conduct as "shabby, unprincipled, and unprofessional" (Pet. App. 17a).

(footnote omitted)). It noted that Oregon law requires hospitals to "insure that procedures exist for granting or restricting privileges of the medical staff and that the medical staff is organized in such a manner as effectively to review one another's professional practices at the facility to reduce morbidity and mortality and to improve patient care" (*id.* at 9a-10a (citing Or. Rev. Stat. §§ 441.030, 441.055(3)(c) and (d) (1985))). Thus, the court said, Oregon has shown an intent to limit consumer choice as to physicians (Pet. App. 11a-12a).

The court of appeals also found that Oregon actively supervises the private parties who engage in peer review, thereby satisfying the second part of the *Midcal* test. The court held that "the combination of" a requirement that hospitals promptly report privilege terminations to the BOME, a requirement that health care facilities regularly review their privilege termination procedures, and the possibility of judicial review of adverse privilege decisions in the Oregon state courts demonstrated active supervision. Pet. App. 10a-11a.⁵ Accordingly, the court of appeals reversed the judgment and remanded the case to the district court for a determination of whether petitioner

⁵ The court of appeals determined that Russell's activities as a member of the BOME also were exempt from antitrust liability under the state action doctrine. In its view, Russell's actions were within the scope of a state official's authority, were taken pursuant to express state policy, and were contemplated by the State. Pet. App. 12a. As we read the petition, no challenge to this holding of the court of appeals has been brought before this Court, and we accordingly express no views on its correctness. We do agree with petitioner (Pet. 19) that, even assuming the correctness of the holding that Russell's BOME activities are state action that cannot directly form the basis for antitrust liability, evidence of those activities is admissible insofar as it provides evidence of a non-immune conspiracy in which Russell and others engaged. Unlike petitioner, however, we do not think that the court of appeals has said anything to the contrary.

had any surviving antitrust claims, independent of the peer review process (*id.* at 2a, 14a).⁶

INTRODUCTION AND SUMMARY OF ARGUMENT

The state action doctrine is “an attempt to resolve conflicts that may arise between principles of federalism and the goal of the antitrust laws, unfettered competition in the marketplace” (*Southern Motor Carriers*, 471 U.S. at 61). The two-part *Midcal* test, requiring clear articulation and active supervision, is meant to ensure that a restraint of trade is immunized from antitrust scrutiny only if it is truly the product of state regulation. Such a restraint is immune because of “the assumption that Congress, in enacting the Sherman Act, did not intend to compromise the States’ ability to regulate their domestic commerce” (*Southern Motor Carriers*, 471 U.S. at 56 (footnote omitted)). A restraint that is merely the product of private anticompetitive activities is not immune, even if the activities fall within a category generally authorized by the state, because a state may not give immunity to private parties merely by “authorizing them to violate [the Sherman Act], or by declaring that their action is lawful.” *Parker v. Brown*, 317 U.S. 341, 351 (1943).

The alleged anticompetitive actions in this case are not the product of state regulation because the second part of the *Midcal* test is not met: Oregon does not supervise its peer review scheme sufficiently to make respondents’ actions fairly attributable to the State. The State provides no review to determine whether a hospital’s termination of a doctor’s privileges conforms in particular instances to the State’s substantive policies. The contrary conclusion of the

⁶ The court of appeals also reversed and remanded the case for a new trial on the state-law claim because the trial court had not properly instructed the jury on state-law immunities (Pet. App. 17a). Petitioner has not asked this Court to review the disposition of his state-law claim by the court of appeals.

court of appeals erroneously affords antitrust immunity in the absence of adequate assurance that the alleged anticompetitive actions were the product of state regulation.

Thus, the judgment of the court of appeals is incorrect whether or not the first part of the *Midcal* test is satisfied, *i.e.*, whether or not the State “clearly intend[ed] to displace competition in [this] field with a regulatory structure” (*Southern Motor Carriers*, 471 U.S. at 64). Because the court of appeals so clearly erred in applying the second part of the *Midcal* test, we will not address the harder question whether the court also erred in applying the first part. See U.S. Amicus Br. 15 (at petition stage).

ARGUMENT

THE COURT OF APPEALS ERRED IN CONCLUDING THAT ALLEGED ANTICOMPETITIVE USE OF OREGON’S PEER REVIEW SCHEME CONSTITUTES “STATE ACTION” IMMUNE FROM THE ANTITRUST LAWS

A. Allegedly Anticompetitive Behavior By Private Parties Constitutes Immune “State Action” Only If The State Exercises Ultimate Control Over That Behavior

This case involves an attempt by private parties, not governmental units, to achieve immunity from Sherman Act liability. As this Court has observed, “[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interest, rather than the governmental interests of the State.” *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 47 (1985); cf. *id.* at 45 (“A private party * * * may be presumed to be acting primarily on his or its own behalf.”). It is for that reason that an “active state supervision” requirement is imposed as “one way of ensuring that the actor is engaging in the challenged conduct pursuant to state policy” (*id.* at 46). Immunity from the federal antitrust laws is warranted only if the state’s program of active supervision offers realistic assurance that, in the judgment

of the state, private parties' exercise of discretion in particular instances furthers a state regulatory policy. Only then can the federal courts be confident that the state is not impermissibly "frustrating the national policy in favor of competition by casting a 'gauzy cloak of state involvement' over what is essentially private anticompetitive conduct" (*Southern Motor Carriers*, 471 U.S. at 57 (quoting *Midcal*, 445 U.S. at 106)).

It is essential to the state action defense that the state exercise ultimate control over the anticompetitive restraint. In the seminal state action case, *Parker v. Brown*, *supra*, this Court stressed that the marketing plan proposed by California raisin growers did not take effect unless and until it was approved by a state board. Similarly, in *Southern Motor Carriers*, 471 U.S. at 51, this Court noted that the state public service commissions "have and exercise ultimate authority and control over all intrastate rates." Most recently, in *324 Liquor Corp. v. Duffy*, No. 84-2022 (Jan. 13, 1987), slip op 9 n.7, this Court held that certain forms of state "monitoring" did not constitute active supervision because they did not "exert[] any significant control over retail liquor prices or mark-ups." See also 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 213b, at 73 (1978) ("The key question here is whether the operative decisions about the challenged conduct are made by public authorities or by the private parties themselves. When the latter is the case, there is insufficient public control to confer antitrust immunity.").

Thus, for respondents to prevail in this case, the Court must find *active* supervision by the State—must find that Oregon exercises "ultimate authority and control" (see *Southern Motor Carriers*, 471 U.S. at 51)—over medical staff peer review decisions or privilege decisions by hospitals. Merely finding some state involvement or monitoring does not suffice. See *id.* at 57; *324 Liquor*, slip op. 9 n.7; *Midcal*, 445 U.S. at 106. And it is respondents

who must demonstrate their entitlement to the state action defense. *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 400 (1978).

B. Respondents Have Not Shown That The State of Oregon Exercises Ultimate Control Over Their Allegedly Anticompetitive Behavior

The court of appeals held that "[t]he combination of [1] internal review by the hospitals, [2] review by the BOME, and [3] review by the courts constitutes adequate supervision" (Pet. App. 11a). Respondents have sought in this Court to defend, and to expand on, each of those three forms of alleged active supervision. Neither the court nor respondents have demonstrated, however, that as part of those three procedures any state official reviewed—or even could have reviewed—the results of this or any other private decision regarding hospital privileges to determine whether state policy has been followed and to correct any abuses.

1. Review of privilege termination procedures by the hospitals themselves and by the state Health Division is not evidence of state control over privilege termination decisions

Oregon has a statutory requirement that, as a condition of maintaining their licenses, hospitals regularly review their peer review procedures for conformity with applicable law (see Or. Rev. Stat. §§ 441.030, 441.055(3)(c) (1985); Br. in Opp. App. 14-17). That requirement, however, is irrelevant to active supervision by the State. The hospital is a private actor, not a representative of the State.

Although the court of appeals did not discuss them, respondents rely on the state Health Division's general supervisory and investigatory powers over health matters, including the licensing of hospitals and the enforcement of health policies (see Or. Rev. Stat. §§ 431.110(1),

431.120(1), 431.140(1), 431.150, 441.025, 441.055 (1985); Br. in Opp. App. 3-8, 12-17). The relevant statutes, however, do not provide for administrative review of private privilege termination decisions.

Whatever the Health Division's power over the establishment of peer review *procedures* by private hospitals,⁷ its activities would not constitute active supervision of private peer review decisions unless the Health Division in fact supervises peer review decisions and has power to overturn a peer review decision that does not conform to state policy. The crux of the complaint in this case is not that peer review procedures are defective, but that private parties used those procedures to eliminate competition by terminating a physician's privileges. Active supervision is meaningful only if such actual decisions made in the peer review process are reviewed. See, e.g., *Midcal*, 445 U.S. at 105-106 (emphasizing the fact that California did not establish prices or review the reasonableness of particular price schedules as a reason for determining that it did not actively supervise the system of price maintenance required by statute); *324 Liquor*, slip op. 9 n.7. And the Health Division offers no such supervision.⁸

⁷ The Health Division may investigate and prosecute violations of public health laws, which presumably would include the statutory requirement that hospitals establish peer review procedures and review them regularly for compliance with state law (Or. Rev. Stat. §§ 431.150, 431.155 (1985); Br. in Opp. App. 6-8). The Health Division may also deny, suspend, or revoke a health care facility's license for failure to comply with that requirement (Or. Rev. Stat. § 441.030(2) (1985); Br. in Opp. App. 14).

⁸ Respondents, but not the court of appeals, have asserted (Br. in Opp. 34 n.8) that a physician who feels aggrieved by the peer review process may file a complaint for administrative relief. Respondents, however, have cited no specific authority for that assertion. The Oregon statute mandating peer review (Or. Rev. Stat. § 441.055(3) (1985)) makes no mention of proceedings to review the result in a par-

2. *The requirement that the state Board of Medical Examiners be promptly notified of decisions to terminate privileges is not evidence of state control over those decisions*

Oregon hospitals are required by statute to notify the BOME promptly of a decision to terminate privileges (Or. Rev. Stat. § 441.820 (1985)). There is, however, no indication that the BOME in fact determines whether the termination of privileges was proper or has authority to remedy any abuse. At most the statute suggests that the BOME will determine whether additional action on its part, such as revocation of a physician's license to practice medicine (see Or. Rev. Stat. § 677.190 (1985)), is warranted. Cf. *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530, 544-545 (5th Cir. 1978) (similar reporting provision in Florida's peer review statute would allow, but not require, the state medical board to take independent disciplinary action against a physician disciplined by peer review), cert. denied, 444 U.S. 924 (1979). The BOME does not have statutory authority to undo hospital termination decisions. Nor have respondents shown that the BOME in practice undertakes any review or that it has ever asserted the authority to reverse the action of a hospital in a termination proceeding. See *Tambone v. Memorial Hosp.*, 825 F.2d 1132, 1134-1135 (7th Cir. 1987).⁹

ticular case. Nor is there specific provision in the statute for administrative orders requiring restoration of hospital privileges to a particular physician or requiring compensation of an injured physician. Rather, the Health Division's enumerated relief powers are limited to proceedings to remedy violations of the statute, which does not specifically prohibit termination of privileges for reasons unrelated to the standard of patient care. Indeed, the statute does not even make provision for a complaining physician to be accorded the status of a party in any investigative proceeding initiated by the Health Division.

⁹ The Seventh Circuit in *Tambone* did not hold, as respondents contend (Supp. Br. in Opp. 3), that active supervision would have existed if there had been mandatory reporting of peer review decisions to the

3. *The possible availability of judicial review of privilege termination decisions under state common law or state antitrust law is not evidence of state control over those decisions*

The typical way in which a state actively supervises private conduct, so as to satisfy the second part of the *Midcal* test, is by giving an administrative agency supervisory authority over that conduct. See generally 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 213 (1978); P. Areeda & H. Hovenkamp, *Antitrust Law* ¶ 212.9e (Supp. 1986). Indeed, it is only in cases involving review by administrative agencies, or state supreme courts with agency-like responsibilities over the organized bar, that this Court has held that there was active supervision. See *Southern Motor Carriers*, 471 U.S. at 62-63 (state public service commissions); *Bates v. State Bar*, 433 U.S. 350, 362 (1977) (state supreme court acting as "policymaker"); *Parker v. Brown*, 317 U.S. at 352 (state agricultural prorate advisory commission). The court of appeals, however, held that Oregon's case law showed that there is judicial review of privilege termination decisions and that the availability of judicial review in state courts is evidence of active state supervision (Pet. App. 11a).¹⁰ Respondents, seeking to

Illinois State Medical Disciplinary Board. Rather, the court noted that legislation enacted after the events in issue in that case, requiring such reporting, "was the first time that there was any supervision of the peer review process by an Illinois agency" (825 F.2d at 1135 (emphasis added)). The court observed that the legislation was "of no avail to defendants" in that case because it was enacted after the relevant events (*ibid.*), and the court had no occasion to comment on what significance the legislation might have for events occurring after its enactment.

¹⁰ In so holding, the court of appeals erroneously relied on *Hoover v. Ronwin*, 466 U.S. 558, 572 n.22 (1984). In *Ronwin* the state supreme court was "acting legislatively rather than judicially" (*id.* at 568), exercising the authority of the sovereign under the state constitution. This Court therefore decided that it "need not address the issues of 'clear articulation' and 'active supervision'" (*id.* at 569).

expand on this holding, point not only to the two Oregon cases cited by the court of appeals, but also to Oregon's antitrust laws and the tort remedies sought in this case, as "clear and convincing evidence of active state supervision through the medium of judicial review" (Supp. Br. in Opp. 9; see *id.* at 5-9; Br. in Opp. 32).

It may perhaps be true that judicial remedies can sometimes play a role in the state's supervision of private conduct for purposes of the state action doctrine. As this Court has noted, establishment of a system of "regulatory oversight" demonstrates a state's commitment to a program of regulation (*Southern Motor Carriers*, 471 U.S. at 61-62 n.23 (quoting 1 P. Areeda & D. Turner, *supra*, ¶ 213a, at 73)), and there is no inherent reason why it must be a state agency rather than a state court that provides such oversight. It should be clear, however, that judicial remedies, if they are to play a central role in the state's supervisory system, must at least be active and measure the allegedly state-endorsed private conduct against the state standards that are claimed to replace competition. The state action doctrine was meant to immunize from antitrust scrutiny conduct that is supervised by the state sufficiently to amount to the state's own conduct, not to substitute any and all state-law judicial remedies for the federal antitrust laws.

The state-law judicial remedies that the court of appeals and respondents cite do not rise to the level of active supervision. It is not even clear that Oregon law affords any sort of "judicial review," in the usual sense, for physicians whose privileges have been terminated by a private hospital. There is no statutory provision for judicial review, and we are aware of no case in which an Oregon court has held that there is judicial review. The cases that respondents (and the court of appeals) cite do not so hold. See *Straube v. Emanuel Lutheran Charity Bd.*, 287 Or. 375, 383, 600 P.2d 381, 386 (1979) ("We have assumed

(but not decided) for the purpose of this case that plaintiff is entitled to 'fair procedure' as a common law right."), cert. denied, 445 U.S. 966 (1980); *Huffaker v. Bailey*, 273 Or. 273, 275, 540 P.2d 1398, 1399 (1975) ("In view of our conclusion that petitioner cannot prevail even assuming the case is properly before us, we find it unnecessary to decide these interesting questions [of reviewability]. Therefore, we assume, but do not decide, that the hospital's decisions are subject to review by mandamus * * *").¹¹

Even assuming that the Oregon courts will eventually resolve the question left open in *Straube* and *Huffaker* by providing some sort of remedy, respondents have made no showing that it would be the kind of judicial review that would constitute active supervision by the State. There is no reason to think a state court would review the merits of the termination of privileges to determine whether the termination served the State's policy of maintaining high standards of patient care rather than respondent's anti-

¹¹ Respondents would infer from a provision of the State's statutory law of evidence that, despite the doubts expressed by the Oregon Supreme Court in *Straube* and *Huffaker*, there must exist some form of judicial review of privilege termination decisions. See Supp. Br. in Opp. 7 (quoting Or. Rev. Stat. § 41.675(5) (1985)). The inference is tenuous. When a state legislature has not provided for any form of statutory judicial review of certain decisions, and the state supreme court has posed but not answered the question whether there exists any form of nonstatutory judicial review, a legislative determination that certain evidence should be admissible when and if judicial review is afforded is hardly compelling evidence of the availability of judicial review. In any event, nothing in the cited statute, which merely governs the admissibility of evidence and does not purport to create or define any right of action, either provides or adverts to any substantive standards that the state courts are to apply when and if they engage in judicial review of privilege termination decisions. Section 41.675(5) therefore provides no evidence at all that state courts will measure privilege termination decisions against the substantive policies of the State to ensure that such policies are carried out.

competitive private interests. To the contrary, any review available would seem to be both deferential and limited to questions of procedural fairness rather than the application of state substantive standards.¹² The Oregon Supreme Court in *Straube* said that a court "should [not] decide the merits of plaintiff's dismissal" and that "[i]t would be unwise for a court to do more than make sure that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care" (287 Or. at 384, 600 P.2d at 386). The same court in *Huffaker* advocated "judicial restraint" and declared that it would not invalidate a decision "made in good faith and supported by an adequate factual basis" (273 Or. at 280-281, 540 P.2d at 1401). This type of review would not result in a determination that substantive state policy was being followed and hence would not make the actions of private parties actions of the State. In the absence of any indication that an Oregon court would judge respondents' conduct against the State's substantive standards, respondents' conduct should be treated as their own and not the State's. See *Town of Hallie*, 471 U.S. at 46-47.

The remedies that might be available to terminated physicians under a state's common law of tort (see Supp. Br. in Opp. 7-8) provide no more basis for a finding of active state supervision than the remedies posited in *Straube* and *Huffaker*. The tort of interference with prospective economic advantage, even if it might be broad enough to encompass some anticompetitive privilege termination decisions, is a common law tort whose elements bear no

¹² As respondent concedes (Supp. Br. in Opp. 6), the Oregon Attorney General views any judicial review that might be available as limited to review of the fairness of procedures and compliance with Health Division requirements, which do not specifically require that private privilege termination decisions implement the state policy of improving patient care.

necessary relationship to any state policy encouraging or regulating the peer review process through which such decisions are made.¹³ Indeed, the existence of any state tort remedy, unless its elements necessarily encompass a full examination of the peer review statute's permissions and prohibitions, is irrelevant. Quite simply, the scrutiny applied to any given conduct in a common law tort action is entirely different in kind from the sort of regulatory scheme, displacing competition, that this Court has treated as active supervision sufficient to satisfy the second part of the *Midcal* test. Certainly, respondents have not shown that Oregon, through its tort law, has "demonstrated its commitment to a program through its exercise of regulatory oversight." *Southern Motor Carriers*, 471 U.S. at 62 n.23 (quoting 1 P. Areeda & D. Turner, *supra*, ¶ 213a, at 73).

Likewise, there is no merit to respondents' suggestion that active supervision exists because "Oregon antitrust laws grant judicial review to hospital-based peer review" (Supp. Br. in Opp. 8). First, if the mere existence of a state antitrust law constituted active state supervision, then the second part of the *Midcal* test would be automatically met in all cases, because all states have antitrust laws (see 13 J. Von Kalinowski, *Antitrust Laws and Trade Regulation* § 132.01, at 132-4 (1987); *id.* App. 132A, at 132A-20 to 132A-27). Such a result would render this Court's previous discussions of active state supervision superfluous.

¹³ Petitioner in this case was awarded damages on the theory that respondents had committed the tort of interference with prospective economic advantage under state law. The reversal of that award by the court of appeals was based on the failure of the trial court to give proper instructions on state-law immunities, not on a rejection of the theory that the tort as pleaded was actionable under state law (see Pet. App. 14a-17a). The trial court instructed the jury that it could find respondents liable in tort based on any of five different actions (see *id.* at 16a n.13; Tr. 2928-2929), one of which related to the peer review process and four of which did not.

Second, respondents' assertion that petitioner has a cause of action under state antitrust law is fundamentally inconsistent with their position that the challenged conduct is protected from the federal antitrust laws under the state action doctrine because state law in this area has displaced the policy favoring free and open competition that underlies both the federal and the state antitrust laws. Oregon's antitrust statute (Or. Rev. Stat. §§ 646.705 *et seq.* (1985)) is modeled on the Sherman Act, and decisions construing federal law are statutorily declared to be "persuasive authority" in construing the Oregon law. Or. Rev. Stat. § 646.715(2) (1985); see 14 J. Von Kalinowski, *supra*, § 169.01, at 169-2. Just as federal antitrust law is designed to ensure "unfettered competition in the marketplace" (*Southern Motor Carriers*, 471 U.S. at 61), the Oregon law is designed "to encourage free and open competition in the interest of the general welfare and economy of the state" (Or. Rev. Stat. § 646.715(1) (1985)). This is the antithesis of what the state action exemption protects — *i.e.*, actively supervised activity pursuant to state regulation designed to displace competition.

In sum, none of the three judicial remedies on which the court of appeals and respondents rely — state common law "judicial review," state tort law, and state antitrust law — amounts to active state supervision. In the absence of such supervision, respondents are not entitled to immunity under the state action doctrine.¹⁴

¹⁴ The quite different immunity provided for in the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, Tit. IV, 100 Stat. 3784-3794 (to be codified at 42 U.S.C. 11101-11152), which was enacted well after the events at issue in this case, does not affect this case. Although the Act in furtherance of "effective peer review" insulates the peer review process from antitrust damage liability in cases covered by the statute, the Act is not retroactive (§ 416, 100 Stat. 3788 (to be codified at 42 U.S.C. 11111 note)), and it expressly provides that it does not change other "immunities under law" (§ 415(a), 100 Stat. 3787 (to be codified at 42 U.S.C. 11115(a))). Moreover, the Act

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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permits antitrust liability if a plaintiff establishes by a preponderance of the evidence that peer review action does not meet the standards specified in the Act, including the requirement that action be taken "in the reasonable belief that [it] was in the furtherance of quality health care" (§ 412(a), 100 Stat. 3785-3786 (to be codified at 42 U.S.C. 11112(a))).

AMICUS CURIAE

BRIEF

No. 86-1145

IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

TIMOTHY A. PATRICK,

Petitioner,

v.

WILLIAM M. BURGET, *et al.*,

Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

BRIEF OF AMICUS CURIAE
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November 24, 1987

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IN THE
Supreme Court of the United States
 OCTOBER TERM, 1987

No. 86-1145

TIMOTHY A. PATRICK,

Petitioner,

v. -

WILLIAM M. BURGET, *et al.*,

Respondents.

On Writ of Certiorari to the United States
 Court of Appeals for the Ninth Circuit

INTEREST OF AMICUS CURIAE

Central and South West Corporation ("CSW") is a public utility holding company which owns four electric utilities operating in Oklahoma, Texas, Arkansas and Louisiana. The CSW system provides electricity to 4.15 million people in a service area of approximately 152,000 square miles. CSW's electric subsidiaries are comprehensively regulated by public utility commissions in the four states where they operate. Accordingly, CSW and its subsidiaries have a vital interest in the state action doctrine at issue in this case. In addition, CSW's Oklahoma subsidiary, the Public Service Company of Oklahoma, now has a case pending in the United States Court of Appeals for the Tenth Circuit, presenting the question of whether

rates set by a state regulatory commission are immune under the state action doctrine. *Lease Lights, Inc. v. Public Service Company of Oklahoma*, No. 86-1797.

In the instant case, the petitioner argues that state action immunity should be rejected because the Oregon law governing hospital peer review does not sufficiently articulate a state policy to displace competition among physician members of a hospital staff with state regulation, and because Oregon does not actively supervise this peer review. CSW is concerned that whatever result the Court may reach in this case, its decision will have an impact far beyond hospital peer review. Since there are fundamental distinctions between the state regulation at issue in this case and that governing electric utilities, and since none of the parties is expected to address these distinctions, CSW submits this brief *amicus curiae* in support of neither party to assist the Court in its resolution of this state action case.¹

STATEMENT OF THE CASE

Amicus curiae adopts the statement of facts set forth in the court of appeals opinion. 800 F.2d 1498.

SUMMARY OF THE ARGUMENT

Immunity from federal antitrust liability for state regulated private parties lies at the core of the *Parker* doctrine. In *Parker*, the Court recognized that our

¹ Pursuant to Rule 36.2 of this Court, CSW has obtained the written consent of the petitioner and respondents to the filing of this brief *amicus curiae*. Copies of those consents have been filed with the Clerk.

principles of federalism require that "state action" be immune from the federal antitrust laws in order to allow the states to implement public policies governing their domestic commerce. In *Southern Motor*, the Court held that if the states were to be free to implement their own governmental policies, this immunity must protect the regulatee as well as the regulator. Such protection for the regulated private party is also supported by basic notions of fairness. A private party who complies with a state regulatory program should not be exposed to treble damage punishment under the antitrust laws for doing so. In addition, state regulatory programs depend upon the voluntary cooperation of those regulated. If the regulatee fears antitrust liability, his willingness to cooperate with the regulator will be diminished and the regulatory program will become unworkable. Thus, state action immunity protects the regulatee in order to assure (a) the states freedom to regulate, (b) fairness to regulated parties and (c) a workable regulatory environment.

These values are critically important in the case of electric utilities. Reliable electric service has become an extremely important ingredient of modern life. As this Court has acknowledged, electric service is regulated by every state "in great detail" (*Pacific Gas*, 461 U.S. at 206) because it "is one of the most important functions traditionally associated with the police power of the States" (*Arkansas Electric*, 461 U.S. at 377) and "represents a clear and substantial governmental interest." *Central Hudson*, 447 U.S. at 569. State regulation of electric utilities is, accordingly, "all-pervasive" and "ubiquitous." *Williams Pipeline*, 21 FERC at 61,624.

As a result, the state regulation of electric utilities is far more comprehensive than the state regulation at issue here. Accordingly, *amicus curiae* respectfully urges the Court to note these important differences in deciding this case.

ARGUMENT

I. State Action Immunity Protects The Regulatee In Order To Assure States The Freedom To Implement Their Governmental Policies, To Prevent Unfairness And To Provide A Workable Regulatory Environment.

As this Court has frequently emphasized,² "the starting point in any analysis of the state action doctrine is the reasoning of *Parker v. Brown*." 317 U.S. 341 (1943).³ California law expressly authorized the

² *Hoover v. Ronwin*, 466 U.S. 558, 567 (1984); *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39 (1985).

³ The deference to state authority recognized in *Parker* was initially forged in *Olson v. Smith*, 195 U.S. 332 (1904). Texas law had established a commission "to fix . . . the charges to be made by . . . pilots for their services" and gave the Governor authority "to appoint such number of branch pilots as may from time to time be necessary." *Id.* at 340. An unauthorized pilot complained that "the commissioned pilots have a monopoly of the business, and by combination among themselves exclude all others from rendering pilotage services." *Id.* at 345. The Court unanimously held that:

[I]f the state has the power to regulate, and in so doing to appoint and commission those who are to perform pilotage services, it must follow that no monopoly or combination in a legal sense can arise from the fact that the duly authorized agents of the state are alone allowed to perform the duties devolving upon them by law.

Id.

creation of a state commission "to restrict competition among the growers and maintain prices." *Id.* at 346. A raisin grower brought an action to enjoin implementation of the plan on the ground, *inter alia*, that it violated the Sherman Act. The Court unanimously reversed the trial court's injunction against the plan, concluding that neither the language nor the history of the Sherman Act indicates "its purpose was to restrain a state or its officers or agents from activities directed by its legislature." *Id.* at 350-51. The Court reasoned that:

In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.

Id. at 351. In so ruling, the Court concluded that:

It is the state which has created the machinery for establishing the prorate program. Although the organization of a prorate zone is proposed by producers, and a prorate program, approved by the Commission, must also be approved by referendum of producers, it is the state, acting through the Commission, which adopts the program and which enforces it with penal sanctions, in the execution of a governmental policy.

Id. (emphasis added).

The reasoning of *Parker* is that states have the sovereign authority to establish and implement public policy within their boundaries without the constraints

of the federal antitrust laws. Although *Parker* involved an action against state officials, rather than the regulated raisin growers, the Court recognized that the federal antitrust laws were not intended "to restrain state action or official action directed by a state." *Id.* at 351 (emphasis added). Thus, *Parker* itself acknowledged the need to protect the regulated private party in order to assure the states sufficient freedom to implement their public policy programs.

Moreover, this protection should apply—the Court reasoned—even where private competitors initiate the proposed restraint and approve it by referendum, so long as "it is the state . . . which adopts the program and which enforces it." *Id.* The Court in *Parker* did not undertake to scrutinize the degree of the state's interest, beyond finding that the state was responsible for establishing the prices and enforcing the final plan. Indeed, under *Parker's* reasoning, such scrutiny would itself run counter to the federalism principles on which it is based.⁴

For example, in *New Motor Vehicle Board of California v. Orrin W. Fox Co.*, 439 U.S. 96 (1978),

⁴ Forty-two years later, in *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985), this Court expressly followed this reasoning by observing that:

Requiring such a close examination of a state legislature's intent to determine whether the federal antitrust laws apply would be undesirable also because it would embroil the federal courts in the unnecessary interpretation of state statutes. Besides burdening the courts, it would undercut the fundamental policy of *Parker* and the state action doctrine of immunizing state action from federal antitrust scrutiny.

471 U.S. at 43 n.7.

California law required automobile manufacturers to obtain approval from a state board before establishing or relocating a dealership. A three-judge federal court declared the California regulation unconstitutional. This Court unanimously reversed, holding, *inter alia*, that:

[The] regulatory scheme is a *system of regulation*, clearly articulated and affirmatively expressed, *designed to displace unfettered business freedom* in the matter of the establishment and relocation of automobile dealerships. The regulation is therefore outside the reach of the antitrust laws under the "state action" exemption.

Id. at 109 (emphasis added). The Court did not undertake to scrutinize the degree of the state's interest, beyond finding that it had created such a system of regulation.

In subsequent cases, the Court has considered whether the state established or reviewed the reasonableness of the challenged restraint. In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980), California law required wine merchants to sell wine at prices posted with the state by wine producers. The Court unanimously held (Justice Brennan not participating) that in order to qualify for immunity, the regulatory scheme must satisfy two tests:

First, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; second, the policy must be "actively supervised" by the State itself.

Id. at 105 (citations omitted). Although the California law satisfied the first test, it did not satisfy the second test because:

The State simply authorizes price setting and enforces the prices established by private parties. *The State neither establishes prices nor reviews the reasonableness of the price schedules*; nor does it regulate the terms of fair trade contracts. The State does not monitor market conditions or engage in any "pointed reexamination" of the program. The national policy in favor of competition cannot be thwarted by casting such a gauzy cloak of state involvement over what is essentially a private price-fixing arrangement.

Id. at 105-06 (footnotes omitted; emphasis added).

Finally, in *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48 (1985), the Court was directly confronted with the question of immunity for regulated private parties. The Public Service Commissions of four southern states comprehensively regulated motor carrier rates and authorized motor carriers to submit collective rate proposals in order to reduce the Commissions' administrative burden. The rates collectively proposed by the motor carriers automatically became effective unless the Commissions took action within a specified period. The United States claimed that the formulation of collective rate proposals by competing motor carriers violated the Sherman Act. The court of appeals rejected state action immunity because although the states articulated a policy in favor of collective rate proposals and actively supervised the resulting rates, they did not "compel" collective ratemaking.

This Court reversed (by 7 to 2 decision), holding that: (1) immunity under *Parker* extends to regulated private parties; (2) compulsion is not required; and (3) private party immunity is governed by the two-pronged test of *Midcal*. In reaching these conclusions, the Court emphasized that:

The *Parker* decision was premised on the assumption that Congress, in enacting the Sherman Act, did not intend to compromise the States' ability to regulate their domestic commerce. If *Parker* immunity were limited to the actions of public officials, this assumed congressional purpose would be frustrated, for a State would be unable to implement programs that restrain competition among private parties. A plaintiff could frustrate any such program merely by filing suit against the regulated private parties, rather than the state officials who implement the plan. We decline to reduce *Parker's* holding to a formalism that would stand for little more than the proposition that Porter Brown sued the wrong parties.

471 U.S. at 56-57 (footnote omitted). *Parker*, *Orrin W. Fox* and *Southern Motor* are all based on the premise that immunity for the state is meaningless unless regulated private parties are also protected.

However, the reasons for shielding regulated private parties go beyond the need to protect state policy implementation. Fairness to the regulated parties also supports this result. As Justice Holmes concluded in *Rock Island, A. & L.R. Co. v. United States*, 254 U.S. 141, 143 (1920): "Men must turn square corners when

they deal with the Government." Once they have "squared the corner" at the Government's request or command, however, it is unfair to punish them under the antitrust laws for doing so. As Areeda and Turner point out, the courts should consider "*fairness for the private defendant caught in the conflicting structures of a federal system.*" I P. Areeda & D. Turner, *Antitrust Law* ¶ 217, at 109 (1978) (emphasis added).

The considerations of fairness are the obvious ones. One should not be punished with treble damages for acts reasonably thought lawful when committed.

*Id.*⁵

Although equity alone is important and perhaps sufficient to justify private party immunity, it is not divorced from *Parker's* basic federalism rationale. The state's interest in implementation of its regulatory program extends beyond merely obtaining obedience to its regulatory command. The state also seeks "ungrudging compliance . . . and voluntary participation in its regulatory structures." *Id.* However, if private parties believe they risk unfair treatment by being caught between the "jaws" of state regulatory policy and antitrust treble damages, then their cooperativeness with the regulatory program will undoubtedly be

⁵ Fairness also requires that a private party who relies on the appearance of legality surrounding a state regulation be protected even if the regulation is subsequently overturned on appeal. This principle is at least implicit in *Bates v. State Bar of Arizona*, 433 U.S. 350, 381 (1977), where this Court found a lawyer advertising prohibition to be immune from antitrust attack even though it had later been held to be unconstitutional. See also, I P. Areeda & D. Turner, *Antitrust Law*, ¶ 212.4b at 132 (Supp. 1987).

chilled.⁶ They may feel constrained to challenge every state regulatory action in order to generate a full record on which to rely for antitrust immunity. If regulated parties adopted this attitude, then every routine state agency proceeding could be transformed into a lawyer's marathon of protest and appeal which would stymie state policy as effectively as the reversal of *Parker* itself.

As a result, in applying *Parker* to shield regulated private parties, there are three interrelated values at stake. First, a state's constitutional power to adopt public policy is meaningless unless it can implement it. In order to implement it, the regulated private party must also be immune. Second, in our system of jurisprudence, a perception of fairness may be as important as our principles of federalism. Third, modern regulatory systems in a nation of 240 million people require the cooperation and voluntary compliance of those regulated. Thus, whether or not fairness constitutes an independent goal, it is at least a necessary "lubricant" in the regulatory "machine". It is not enough that states be allowed to enforce their policies; they must be able to rely on widespread, voluntary compliance or else the system will break down. To achieve this, those regulated must believe that they will not be treated unfairly by being exposed to conflicting policies in our federal system.

For these reasons, the application of the state action doctrine to protect regulated private parties is not a mere appendage to the reasoning of *Parker*; rather, it lies at its core.

⁶ See, e.g., *Hoover v. Ronwin*, 466 U.S. 558, 580 n.34 (1984); *Harlow v. Fitzgerald*, 457 U.S. 800, 814 (1982).

II. This Policy Basis For State Action Immunity Is Critically Important In The Case Of Electric Utilities Because They Are So Comprehensively Regulated By The State.

As this Court has long recognized, state regulation of electric utilities is unique in its deep historical roots and comprehensive scope. Justice Brandeis observed almost sixty years ago that:

[A] franchise to operate a public utility is not like the general right to engage in a lawful business, part of the liberty of the citizen; . . . it is a special privilege which does not belong to citizens generally. . . .

Frost v. Corporation Commission of Oklahoma, 278 U.S. 515, 534 (1929) (Brandeis, J., dissenting).

In *Pacific Gas and Electric Co. v. Commission*, 461 U.S. 207 (1983), the Court pointed out that:

[The] economic aspects of electrical generation have been regulated for many years and in great detail by the States.

. . .

As early as 1920, many States had adopted legislation empowering utility commissions to regulate electric utilities. Today, every State has a regulatory body with authority for assuring adequate electric service at reasonable rates.

Id. at 206 and 206 n.17 (citations omitted; emphasis added).

Indeed, as the Court noted in *Arkansas Electric Co-operative Corp. v. Arkansas Public Service Com-*

mission, 461 U.S. 375, 377 (1983): "the regulation of utilities is one of the most important functions traditionally associated with the police power of the States." Similarly, in *Central Hudson Gas & Electric Corp. v. Public Service Commission of New York*, 447 U.S. 557, 569 (1980) the Court emphasized that: "The State's concern that rates be fair and efficient represents a clear and substantial governmental interest."

Even with respect to nuclear power plants, which the federal government extensively regulates, the Court has recognized that:

the States retain their traditional responsibility in the field of regulating electrical utilities for determining questions of need, reliability, cost, and other related state concerns.

Pacific Gas, 461 U.S. at 205; see also *FERC v. Mississippi*, 456 U.S. 742, 772 (1982) (Powell, J., concurring in part and dissenting in part) ("As these utilities normally are given monopoly jurisdiction, they are extensively regulated both substantively and procedurally by state law") (emphasis added); *Central Hudson Gas & Electric Co.*, 447 U.S. at 587 (Rehnquist, J., dissenting) ("a utility is far closer to a state-controlled enterprise than is an ordinary corporation") (emphasis added); *Consolidated Edison Company of New York v. Public Service Commission of New York*, 447 U.S. 530, 550 (1980) (Blackmun, J., dissenting) ("This exceptional grant of power to private enterprises justifies extensive oversight on the part of the State") (emphasis added).

Both Congress and the Federal Energy Regulatory Commission have also acknowledged this extensive state regulation of electric utilities. See, e.g., H.R. Rep. No. 1750, 95th Cong., 2d Sess. 97 (1978) and S. Rep. No. 1292, 95th Cong., 2d Sess. 97 (1978) (acknowledging the intense "type of examination that is traditionally given to electric utility rate applications"); S. Rep. No. 442, 94th Cong., 2d Sess. 9 (1977) (federal standards would unnecessarily intrude "into an area which has *traditionally been regulated by the States*") (emphasis added); *Williams Pipeline Co.*, 21 FERC ¶ 61,260 at 61,592 (1982) (the "intrastate and retail branches [of electric power] are *subject to all-pervasive state regulation*") (emphasis added); *id.* at 61,624 (franchised electric power monopolies have long been characterized by "*pervasive controls [and] ubiquitous regulation*") (emphasis added).

As these authorities demonstrate, electric utility regulation has at least four distinctive features which are relevant to analysis under *Parker*. First, reliable electric service has become an extremely important feature of modern American life. One need only consider the tremendous inconvenience caused by a temporary loss of power during a storm to appreciate the reality of our universal dependence on electric power. Thus, electric power presents issues of the highest social importance.

Second, because of this social importance and the states' time-honored and primary responsibility in the area, state regulation of electric utilities "is one of the most important functions traditionally associated with the police power of the States." *Arkansas Electric*, 461 U.S. at 377. It "represents a clear and sub-

stantial governmental interest." *Central Hudson*, 447 U.S. at 569.

Third, unlike many regulatory programs which arise among the states, the regulation of electric utilities is universal—"every State has a regulatory body with authority for assuring adequate electric service at reasonable rates." *Pacific Gas*, 461 U.S. at 206 n.17.

Fourth, electric utilities have traditionally been subject to comprehensive regulation. This Court has characterized this pattern of regulation as being "in great detail." *Pacific Gas*, 461 U.S. at 206. The FERC has referred to it as "all-pervasive" and "ubiquitous regulation." *Williams Pipeline*, 21 FERC at 61,624.

Under these unique circumstances, the values at stake in applying *Parker* to regulated private parties take on heightened importance. The state's interest is stronger and the need for freedom from antitrust constraints to implement their policies is also stronger. Fairness to the regulated party is also more critical. The "all-pervasive" regulation of electric utilities would encounter regulatory "grid lock" without the voluntary cooperation of those regulated. For these reasons, the values which underlie *Parker* and *Southern Motor* are critically important for both the states and the utilities in the case of regulated electric power.

III. The Comprehensive State Regulation Of Electric Utilities Is Significantly Different From The Hospital Peer Review System At Issue Here And Satisfies The Tests Of *Midcal*.

As the discussion in Part II demonstrates, the pattern of state regulation of electric utilities is far more comprehensive than the hospital peer review system

at issue here. The Court's state action opinions are directed to distinguishing between state and private action. The two-pronged test of *Midcal* is essentially an analytical and evidentiary aid in making this distinction.

On the "clear articulation" prong of *Midcal*, electric utility regulation is far different from peer review. In the typical state electric utility regulatory regime, the state not only clearly articulates specific policies to displace competition over such matters as service and territories, but it also establishes a comprehensive and "inherently anticompetitive rate-setting process." *Southern Motor*, 105 S. Ct. at 1730.

On the "active supervision" prong of *Midcal*, there are a number of important differences. At bottom, this test is designed to determine whether a state agency is—in the words of *Bates v. State Bar of Arizona*, 433 U.S. 350, 350 (1977)—"the ultimate body wielding the State's power." The ruling in *Midcal* suggests that the state may wield the ultimate power either by establishing the challenged restraint itself or by reviewing the reasonableness of the restraint established by private parties. Immunity was rejected in *Midcal* precisely because the state "neither establishes prices nor reviews the reasonableness of the price schedules." 445 U.S. at 105.

In *Southern Motor* the Court explained more fully what it meant by "review":

This active supervision requirement ensures that a state's actions will immunize the anticompetitive conduct of private parties only when the "state has demonstrated its commitment to a program through its exercise

of regulatory oversight." See I P. Areeda & D. Turner, *Antitrust Law*, ¶ 213a, p. 73 (1978).

471 U.S. at 62 n.23. Such "regulatory oversight" does not require that the state agency actually hold a hearing, or take evidence, or even write a decision in every case. In *Southern Motor*, for example, the Court found state action immunity even where "[a] proposed rate becomes effective if the state agency takes no action within a specific period of time." 471 U.S. at 50-51.

Indeed, the federalism basis of *Parker* should preclude federal courts from second-guessing the intensity of the state's scrutiny, so long as the state agency either establishes the restraint or has the opportunity to review it. As Areeda and Turner conclude:

The federalism concerns at the heart of *Parker* cannot be reconciled with federal court probing of the "true" motives of state legislatures and agencies. . . . There simply is no way to tell if the state has "looked" hard enough at the data, and there certainly are no manageable judicial standards by which a court may weigh the various elements of a "public interest" judgment in order to determine whether the legislature or agency decision was correct. . . .

Moreover, it can hardly be said that this position leaves state agencies any freer than their federal counterparts. . . . There seems little reason to hold state agencies to a higher standard, particularly when Congress has been silent on the matter. Thus, we conclude

that an allegation that state officials customarily "rubber stamp" the self-interested decisions or recommendations of the private parties involved should not ordinarily oust *Parker* immunity.

I P. Areeda & D. Turner, *Antitrust Law*, ¶ 213c (1978).

Under the *Midcal* two-pronged test, immunity arises when there is a clear state policy and active supervision. *Midcal* does not require that the state provide opportunities for interested parties to contest the restraint in question. However, state regulatory systems which provide those opportunities, as many in fact do, should enjoy even greater deference by the federal antitrust courts.

Notice and an opportunity for affected parties to complain about alleged competitive impacts is probative of the state's "commitment to a program." Moreover, as this Court has recognized in another context, such elements of "due process" tend to assure the fairness of the regulatory decision-making and thereby "help in effectuating antitrust policies by discouraging anticompetitive applications of . . . rules which are not justifiable." See, e.g., *Silver v. New York Stock Exchange*, 373 U.S. 341, 362-63 (1963). As a result, opportunities for disputes about competitive impacts to be heard and resolved by a state agency are helpful, but are not essential for state action immunity.

Measured against these standards, electric utility regulation is both far more comprehensive than the regulatory system at issue in this case and well within the *Midcal* test. Rates, service areas and other facets

of electric service are typically established by the state agency.⁷ This alone constitutes adequate "state supervision" under *Midcal* and *Southern Motor*. In addition, affected parties are typically given notice and an opportunity to participate in administrative proceedings conducted by the agency.⁸ The State agency typically maintains regular oversight of virtually all of the regulated party's activities.⁹ And, the state

⁷ Under Oklahoma law, for example, the Oklahoma Corporation Commission is expressly directed by state law to "prescribe and enforce . . . such rates . . . as may be reasonable and just." Okla. Const. art. IX, § 18; see Okla. Stat. tit. 17, § 152. Commission regulations expressly provide that:

It shall be unlawful for a utility to furnish, charge for or receive payment for electric service except strictly in accordance with a tariff, special contract or rate schedule approved by and on file with the Commission.

Rule 5, General Rules and Regulations Governing the Operations of Electric Utilities (adopted May 1, 1974).

⁸ For example, under the Oklahoma Constitution, the Oklahoma Corporation Commission provides notice of rate proceedings to the public, holds evidentiary hearings when necessary and has the full power of a court of record to administer oaths, compel attendance of witnesses and production of documents, levy fines and hold parties in contempt. Okla. Const. art. IX, § 19. Commission orders are reviewable on appeal to the Supreme Court of the State. Okla. Const. art. IX, § 20; Okla. Stat. tit. 17, § 7. Any aggrieved party, even one who did not participate in Commission proceedings, may appeal. *Gulf C. & S.F. Ry. v. State*, 110 P. 651 (Okla. 1910).

⁹ In Oklahoma, for example, the Commission is authorized to hire, and in fact maintains, a staff of auditors, investigators and attorneys. Okla. Stat. tit. 17, §§ 31-33. See also 11 Op. Att'y Gen. Okla. 107 (1979) (Funds appropriated to the commission may be spent to employ outside experts to evaluate utility rate applications); 12 Op. Att'y Gen. Okla. 264 (1980) (State Attorney

agency members are themselves customarily elected or appointed by the governor and have no pecuniary interest in the outcome of the regulatory process.¹⁰

Thus, state regulation of electric utilities is critically different from the state regulation at issue in this case. As a result, freedom for the states to implement their public policies, fairness to the regulated party and the encouragement of voluntary cooperation by those regulated all support state action immunity for regulated electric utilities.

CONCLUSION

Because of the vital importance of state action immunity to regulated electric utilities, *amicus curiae*

General can request the State Auditor and Inspector to provide experienced personnel to investigate and testify about rate applications). In addition, virtually all Oklahoma electricity rates now include a fuel adjustment clause. In 1977, the State Legislature required the Commission to "continually monitor and oversee application of the fuel adjustment clauses," to hold public hearings on them at least every six months and to "conduct detailed rate investigations of such utilities and cooperatives." Okla. Stat. tit. 17, §§ 252 and 263. Indeed, regulated electric utilities have been required to submit monthly reports on rate compliance under these clauses to the Commission, the Governor and the State Legislative Council. Okla. Stat. tit. 17, § 253. This statute was amended in 1981 to substitute the Speaker of the House and the President *Pro Tempore* of the Senate of the State Legislature for the Legislative Council.

¹⁰ This Court has long recognized "that those with substantial pecuniary interest in legal proceedings should not adjudicate these disputes." *Gibson v. Berryhill*, 411 U.S. 564, 579 (1973) (state-appointed optometrists board could not constitutionally terminate licenses of all optometrists employed by corporations because board members had a significant pecuniary interest in the result).

urges the Court to note the distinctions between the typical electric utility regulatory regime and the regulatory regime it confronts in this case and avoid a formulation which would call into question the immunity of the nation's regulated electric utilities.

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AMICUS CURIAE

BRIEF

(11)

No. 86-1145

Supreme Court, U.S.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

TIMOTHY A. PATRICK, M.D.,
Petitioner,
v.

WILLIAM M. BURGET, M.D., *et al.*,
doing business as ASTORIA CLINIC,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

**BRIEF FOR AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF PETITIONER**

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**BRIEF FOR AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF PETITIONER**

INTEREST OF AMICUS CURIAE

The American Psychological Association ("APA"), a nonprofit scientific and professional organization founded in 1892, is the major association of psychologists in the United States. The APA has more than 70,000 members, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. The purpose of the APA, as set forth in its bylaws, is to "advance psychology as a science and

profession, and as a means of promoting human welfare by the encouragement of psychology in all branches and in the broadest and most liberal manner." A substantial and growing number of the APA's member psychologists are health-care providers licensed to provide mental health services to individual clients.

The APA believes it has a unique perspective on the issue of the proper application of the antitrust laws to hospital peer review decisions, which will be of value in resolving the present case. The APA is actively involved in the provision of quality assurance for the profession of psychology, including such programs as accreditation of doctoral programs in professional psychology, promulgation of ethical standards and guidelines for the delivery of psychological services, and establishment of peer review on a nationwide basis to provide consumers and third-party payors with a formal but readily accessible avenue of redress should a question arise regarding the reasonableness or necessity for mental health services. Aware of peer review's potential for enhancing public health and welfare, the APA has an interest in assuring that the antitrust laws do not needlessly chill these valuable quality assurance programs for health care.

But APA members who are health-care providers have an interest in ensuring that peer review is not abused for anticompetitive purposes. These anticompetitive risks are particularly acute with respect to hospital credentialing and peer review procedures governing access to hospital privileges. Physicians have historically opposed recognition of psychologists as independent health care providers and may have viewed the economic competition offered by psychologists as threatening. Yet courts reviewing physicians' exclusionary policies as applied to psychologists have typically found them to be unrelated to achievement of genuine health care objectives, and harmful to the public's interest in receiving the best care at reasonable rates. *See, e.g., Virginia Academy of Clin.*

Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). Because hospital peer review committees are typically controlled by physicians, psychologists face the risk of systematic denial of hospital privileges as a result of parochial, anticompetitive, or misguided motivations, rather than a genuine and empirically valid interest in assuring quality health care. Hospital privileges constitute an important—even essential—competitive advantage for many practitioners. Accordingly, the APA has an interest in ensuring that hospital peer review remains subject to appropriate antitrust scrutiny to avert the special risks posed by peer review conducted in the interdisciplinary and interprofessional context.

APA has appeared as *amicus curiae* before this Court in cases raising issues of health antitrust law and federalism. *E.g., Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts*, 471 U.S. 724 (1985); *Blue Shield v. McCready*, 457 U.S. 465 (1982).

The parties have consented in the filing of this brief *amicus curiae* pursuant to Rule 33 of the rules of this Court. Their letters of consent will be filed with the Clerk of this Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents the issue whether a bad faith, anticompetitive revocation of a physician's hospital privileges by the peer review committee of an Oregon hospital is exempt from federal antitrust liability by virtue of "state action" immunity, as set forth in *Parker v. Brown*, 317 U.S. 341 (1943), and its progeny. The case therefore requires this Court to reconcile the Sherman Act's goal of ensuring vigorous, unfettered economic competition with a federalism goal of preserving state power to supplant economic competition in limited areas to achieve particular objectives.

The court of appeals in this case failed to strike the proper balance between these interests, and thereby created the risk—not addressed by any party—that unchecked physician control of the hospital peer review process will lead to a systematic exclusion of competition from other licensed health care professionals, such as psychologists. *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986). The court held that the hospital peer review decision challenged in this case was clearly authorized under Oregon law and was actively supervised by the State. See *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48, 57 (1985) (stating test). The court found that section 441.055(3), Or. Rev. Stat., supplied a clearly articulated state policy to supplant competition in the provision of health care services in hospitals. The court also found that the State actively supervised this policy through general oversight by the State Health Division, a requirement that peer review decisions denying privileges be reported to the Board of Medical Examiners (“BOME”), and judicial review. 800 F.2d at 1506.

This decision seriously misconstrues the nature and scope of “state action” antitrust immunity. The peer review challenged in the present case was found by the jury to be a bad faith effort to exclude competition, not a good faith decision based on the need to improve medical care. See Transcript 2922 (jury instruction). *Amicus* will demonstrate that immunizing this naked restraint was not necessary to further any clearly articulated policy of the State of Oregon. In requiring hospital peer review, the State articulated a policy to displace competition for the limited purposes of “reducing morbidity and mortality and for the improvement of patient care.” Or. Rev. Stat. § 441.055(3). The State had no intention to permit or promote use of the peer review process for the sole purpose of excluding competitors. Moreover, the court of appeals overlooked a crucial fact that arguably disposes of the state action issue. *The*

State of Oregon itself explicitly permits civil actions, including state antitrust actions, for conduct by hospital peer review committees that is not undertaken “in good faith” to promote health objectives. Or. Rev. Stat. § 41.675(4). No purpose of federalism is served by immunizing from federal antitrust scrutiny particular anti-competitive conduct for which the State itself imposes state antitrust liability. (Point I.A.) Nor are hospital peer review decisions “actively supervised” within the meaning of this Court’s decisions. Neither the State Health Division, nor the BOME, nor the state courts have any authority to conduct a “pointed reexamination” of particular peer review decisions to ensure that the decisionmaking power has been exercised in conformity with the purposes for which it was granted. (Point I.B.)

Amicus will also demonstrate that the court of appeals’ indiscriminating grant of “state action” immunity for hospital peer review decisions threatens serious anti-competitive consequences that contravene the Sherman Act and the clear policies of most States. Although properly conducted and supervised peer review can enhance both the quality of health services and competition in the market for provision of those services, the hospital peer review process does present systemic anticompetitive risks where physicians control peer review committees and use that control to exclude competition from other health care professionals, such as psychologists. Overbroad grants of state action immunity for peer review will exempt this anticompetitive conduct from the antitrust laws, and thereby thwart both federal and state policies permitting and encouraging the provision of health care and mental health care by licensed professionals other than physicians. Neither the parties to this action nor the court of appeals have focused on the risk that arises in the interprofessional context, because the facts here do not directly raise it. But in resolving the state action issue before it, this Court should be aware of these serious, unintended anticompetitive consequences

of the sweeping immunity provided by the court of appeals in this case. (Point II.)

ARGUMENT

I. "STATE ACTION" IMMUNITY IS INAPPLICABLE IN THE CIRCUMSTANCES OF THIS CASE BECAUSE THE CHALLENGED PEER REVIEW DECISION DENYING PETITIONER HOSPITAL PRIVILEGES WAS NEITHER IN FURTHERANCE OF A CLEARLY ARTICULATED STATE POLICY NOR CLOSELY SUPERVISED BY THE STATE, AND ITS IMPOSITION WOULD NEEDLESSLY THWART THE FREE MARKET GOALS OF THE SHERMAN ACT.

In *Parker v. Brown*, based on an assumption that Congress did not intend the antitrust laws to nullify state power to displace unfettered competition for valid public health and welfare purposes, this Court held that the Sherman Act did not prohibit States from imposing restraints on competition. 317 U.S. at 351. See *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. at 55-56.

In developing the *Parker* doctrine, this Court has also made clear that antitrust immunity for "state action" may shield the anticompetitive conduct of private parties, but only if the party claiming the immunity can demonstrate that the challenged conduct meets this Court's two-part test. *First*, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy." *Id.* at 57 (internal quotation and citation omitted). *Second*, "the state must supervise actively any private anticompetitive conduct." *Id.* Accord 324 *Liquor Corp. v. Duffy*, — U.S. —, —, 93 L.Ed.2d 667, 677 (1987); *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980). See generally *City of Lafayette v. Louisiana Power and Light Co.*, 435 U.S. 389, 400 (1978) (party seeking immunity bears burden of persuasion). Within the limited

confines defined by the two-part test, state action immunity reconciles the federalism interest in preserving state power to regulate in ways that may displace some competition and the Sherman Act's goal of preserving vigorous free markets. *Southern Motor Carriers*, 471 U.S. at 61.

Amicus will show that the conduct of the hospital peer review board challenged in the present case deserves no exemption from the federal antitrust laws because it meets neither of the requirements for state action immunity. The court of appeals' erroneous finding of "state action" therefore thwarted the important pro-competitive goals of the Sherman Act without measurably advancing the public health policies of the State of Oregon.

A. The Hospital Peer Review Decision Challenged In This Case Was Not Made In Furtherance Of A Clearly Articulated State Policy.

The first part of this Court's test for "state action" immunity—whether the state policy allegedly justifying a restraint is "clearly articulated and affirmatively expressed," *Southern Motor Carriers*, 471 U.S. at 57; *Midcal Aluminum, Inc.*, 445 U.S. at 105—demands a careful analysis of the scope of any state policy claimed as a justification for displacement of private economic competition. This careful scrutiny is imperative to striking the appropriate balance between the Sherman Act and the state's interest in displacing competition for particular policy reasons. It serves no purpose of federalism to immunize private anticompetitive conduct from the federal antitrust laws when the State has expressed no interest in promoting the conduct, especially when, as here, the State imposes liability for the conduct.

The court of appeals in the present case failed to undertake a careful analysis of the scope of the state policy at issue. The court correctly recognized that Oregon required peer review *only* "for the purposes of reducing

morbidity and mortality and for the improvement of patient care," Or. Rev. Stat. § 441.055(3)(d), and sought *only* to "replace pure competition with *some* regulation," 800 F.2d at 1506 (emphasis added). Furthermore, the State itself permits persons situated like petitioner to sue members of peer review committees for actions taken in bad faith, and not for medical reasons. Or. Rev. Stat. § 41.675(4). Yet the court of appeals concluded that "federal antitrust laws are simply displaced" by Oregon's peer review policy, *id.* at 1507, irrespective of whether the peer review process was abused for an anticompetitive end having nothing whatsoever to do with the State's policy of "reducing morbidity and mortality" or "the improvement of patient care," and whether or not it was made "in good faith." As a result of this indiscriminating approach, the court of appeals immunized a peer review committee's decision to revoke hospital privileges, despite a jury finding that the committee acted in bad faith to restrict economic competition.¹ In so doing, the court of appeals carved out a state action immunity far broader than is permitted under the decisions of this Court, and imposed a senseless restriction on the scope of federal antitrust law far broader than was necessary to vindicate Oregon's state policy requiring peer review.

Although a party "need not point to a specific, detailed legislative authorization" to establish a clearly articulated state policy, *City of Lafayette v. Louisiana Power and Light Co.*, 435 U.S. at 415 (opinion of Brennan, J.), this Court has consistently required a clear showing that the State intends to displace competition *in the way that the challenged restraint does*. Restraints unrelated to,

¹ The jury was instructed that it could not find for petitioner on the Sherman Act section 2 claim if it found that respondents were "motivated by concerns over the provision of health care to the community" (Transcript 2922). The jury found for petitioner on that claim. The court of appeals found ample evidence to support the jury finding of bad faith. 800 F.2d at 1507.

or significantly in excess of, those necessary to effectuate a state policy are not shielded from antitrust scrutiny. In such cases there is no reason to thwart the federal interests in vigorous enforcement of the antitrust laws. *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).²

In *Goldfarb*, this Court declined to immunize the efforts of state and county bar associations to set a mandatory minimum fee schedule for lawyers in Virginia. The Virginia Supreme Court, acting as sovereign, had adopted ethical codes directing attorneys determining appropriate fees to consider any schedules of minimum fees adopted by a bar association. This Court held that the existence of a state policy favoring *advisory* fee schedules was not sufficiently broad to justify the bar associations' efforts to establish essentially *mandatory* minimum fee schedules. In fact, as the Court found, the Virginia Supreme Court had expressed only a limited anticompetitive policy and directed attorneys not "to be controlled" by fee schedules. 421 U.S. at 789-790. Because the mandatory fee schedule significantly exceeded the limited goals of the state supreme court, the grant of immunity for that conduct would not further any articulated state policy. Under those circumstances, the Court held, there was no warrant for thwarting the procompetitive ends of the Sherman Act.³

² See also *Ratino v. Medical Service of the District of Columbia*, 718 F.2d 1260, 1268 n.22 (4th Cir. 1983); *Corey v. Look*, 641 F.2d 32, 37 (1st Cir. 1981) (requiring showing that "challenged restraint is necessary to the successful operation of the legislative scheme that the state sovereign has established").

³ This Court's recent decision in *Southern Motor Carriers* understood the holding in *Goldfarb* in this way. Respondents had argued that *Goldfarb* stood for the proposition that state action immunity was appropriate only when the state compelled anticompetitive private conduct. Rejecting this argument, the Court in *Southern Motor Carriers* explained that state action immunity in *Goldfarb* was inappropriate because the state had no clearly articulated policy

Similarly, in *Cantor* this Court held that a utility whose rates for electricity were subject to state regulation could not claim immunity for other anticompetitive conduct unrelated to the provision of electricity—in particular, the provision of free light bulbs to customers. As in *Goldfarb*, the Court in *Cantor* carefully evaluated the scope of articulated state policies allegedly supporting a claim of immunity to ensure that the important procompetitive goals of the Sherman Act were not sacrificed unnecessarily.⁴

This Court has employed a similar approach to reconcile the Sherman Act with competing federal policy goals that require some displacement of competition. In recognition of “the indispensable role of antitrust policy in the maintenance of a free economy,” *United States v. Philadelphia Nat’l Bank*, 374 U.S. 321, 348 (1963), this Court has repeatedly held that implied antitrust immunities are disfavored. *Id.* at 350-351; *see also, e.g., National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 388-389 (1981); *United States v. National Association of Securities Dealers*, 422 U.S. 694, 719-720 (1975); *United States v. Philadelphia Nat’l Bank*, 374 U.S. at 350-351. Even in the rare instances when such immunities are recognized, they are strictly construed to prevent unnecessary restriction of Sherman Act enforcement. *E.g., Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979); *Silver v. New York Stock Exchange*, 373 U.S. 341, 357-358 (1963).

Unlike the court of appeals in the present case, which “simply displaced” the antitrust laws, 800 F.2d at 1507,

to displace competition in the way the defendants had, i.e., with a mandatory fee schedule. 471 U.S. at 60-61.

⁴ *Cf. Community Communications Co. v. Boulder*, 455 U.S. 40 (1982) (State’s general “home rule” authorization to city did not constitute clearly articulated state policy to permit city to displace competition in cable television market).

this Court in *Silver v. New York Stock Exchange*, for example, held that “the proper approach . . . is an analysis which reconciles the operation of both statutory schemes with one another rather than holding one completely ousted.” 373 U.S. at 357 (emphasis added). At issue in *Silver* was the extent to which the Sherman Act’s prohibition of anticompetitive boycotts applied to conduct of a securities exchange authorized under the Securities Exchange Act of 1934 to engage in self-regulation that included disciplining securities dealers. Given the important national policies served by the Sherman Act, the Court held that “the guiding principle to reconciliation of the two statutory schemes” was that antitrust immunity be granted only “to the minimum extent necessary” to achieve the competing policy goals of the securities laws. *Id.*; *see also id.* at 361. Applying these principles, the Court refused to immunize a boycott of a securities dealer by the stock exchange. Because the exchange had not afforded the dealer notice or opportunity to challenge the decision to boycott, the Court concluded, antitrust immunity would further “[n]o policy reflected in the Securities Exchange Act.” *Id.* at 361.

The principles of *Goldfarb*, *Cantor*, and *Silver* should govern the present case. Oregon has articulated a policy that displaces competition in the medical field to only a limited extent and for only certain purposes. The statutory provision that allegedly supplies the clearly articulated and affirmatively expressed policy of the State authorizing peer review committees to deny hospital privileges for anticompetitive reasons is Or. Rev. Stat. § 441.055(3)(d). That provision requires hospitals, as a condition of obtaining and maintaining a license from the State Health Division, to “[i]nsure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care.” *Id.* (emphasis added).

The statute merely permits a committee of physicians to make decisions about a fellow health care professional's ability to provide medically competent treatment. Peer review *does* displace free-market forces to a limited extent; the committee, rather than the market, determines the "quality" of a practitioner's skills, and if the committee finds the skill level to be inadequate then the practitioner is excluded from the market entirely. But this statutory provision is not intended to ensure the reviewing physicians the economic benefits of monopoly power by permitting them to restrict competition for economic reasons. Compare *Parker v. Brown*, 317 U.S. at 346 (state policy "to restrict competition among [raisin] growers and maintain prices in the distribution of their commodities"). Oregon thus has not articulated a state policy to supplant competition for hospital privileges in its entirety, but only to the extent necessary to advance the State's articulated policy goal of reducing morbidity and mortality and improving patient care.

Critically, Oregon itself has evinced no interest in absolutely immunizing privilege decisions of hospital peer review committees, irrespective of the reasons for their decisions. Oregon grants members of such committees only *limited* immunity. Or. Rev. Stat. § 41.675(4). Section 41.675(4) provides that "[a] person serving on or communicating information" to a hospital peer review committee "shall not be subject to an action for civil damages for affirmative actions taken or statements made *in good faith*." *Id.* (emphasis added). When a peer review committee denies or revokes privileges to restrict competition, and not to ensure competent health care, committee members are subject to a range of possible civil liability, *including liability under Oregon's state antitrust laws*. See Or. Rev. Stat. § 646.725 (prohibiting restraints of trade, language identical to Sherman Act).

In this case, the jury found that the peer review process was abused for the purpose of excluding a com-

petitor from access to an essential facility by denying hospital privileges. This anticompetitive conduct can in no sense be said to further the substantive interests the State of Oregon seeks to advance in its hospital peer review statute. Far from granting immunity "to the minimum extent necessary" to permit achievement of the articulated state policy, *Silver*, 373 U.S. at 357, the court of appeals immunized anticompetitive conduct unrelated to, and significantly in excess of, the type of conduct that the State seeks to encourage. Indeed, under Oregon's own antitrust laws, the State actually makes actionable the very conduct the court of appeals would immunize from federal law in the name of federalism.

Because Oregon has articulated no substantive interest in immunizing peer review decisions taken for the purpose of restricting competition, granting "state action" immunity to such anticompetitive conduct could be thought necessary, and therefore compelled by the federalism purpose underlying state action immunity, only for "prophylactic" reasons. If the threat of antitrust liability for bad faith conduct would chill or distort the performance of hospital peer review and thereby thwart the articulated state interest, then blanket immunity might arguably be necessary to achieving the goals of the state policy. Such an argument has no force in the present case, however, because the State of Oregon itself permits the imposition of tort liability and, most importantly, the imposition of *state antitrust liability* for anticompetitive actions of peer review committees undertaken for the purpose of restricting or eliminating competition, and not for purposes of promoting health care. Oregon itself has decided that blanket immunity is *not* necessary to advancement of the state policy objectives articulated in section 441.055(3)(d). No federalism purpose is served by granting antitrust immunity to conduct, like that at issue in this case, that is specifically actionable under state antitrust law.

Although not dispositive, the conduct of the federal government in reconciling federal policy to promote peer review with the antitrust laws is persuasive authority for the position urged here. The Health Care Quality Improvement Act of 1986 immunizes peer review decisions from antitrust liability, but only if the decisions are made in good faith after reasonable investigation and in fair proceedings, and not for exclusionary reasons. 42 U.S.C. §§ 11101 *et seq.* See also 132 Cong. Rec. H11590 (daily ed. October 17, 1986) (statement of Rep. Waxman) ("Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540"). Congress concluded that a limited threat of antitrust liability for bad faith anticompetitive conduct would not so seriously chill peer review and thereby jeopardize its pro-health (and procompetitive) benefits as to justify accepting the dangers to competition entailed by absolute immunity. The State of Oregon has made a judgment similar to that of Congress with respect to state liability for abuse of the peer review process. There is thus neither a substantive nor a prophylactic need to grant absolute immunity for hospital peer review in order to advance the state policy expressed in Or. Rev. Stat. § 441.055(3)(d). Indeed, to grant immunity when neither the state nor federal legislatures thought it necessary, and when both apparently considered it undesirable, would utterly pervert the concept of federalism.⁵

⁵ Because antitrust liability will be imposed only for bad faith peer review decisions based on intent to exclude a competitor, and not on health-related criteria, there can be no claim in this case that a refusal to recognize state action immunity will result in overly intrusive federal judicial supervision of state decisionmaking or in inappropriate "second-guessing" of state decisionmakers. Under the standard urged here, federal courts would not impose antitrust liability for "mere error" in the execution of a clearly articulated state policy. Only if a defendant is shown to have been motivated by bad faith anticompetitive purposes unrelated to, or significantly in excess of, the scope of the state policy, will the antitrust laws even be implicated. Thus, there is no serious risk

If there is no federalism reason in this case for immunizing anticompetitive peer review decisions made for the purpose of eliminating competition, then the mere fact that application of the Sherman Act may result in burdening the federal courts with supervision of the peer review process is not a sufficient justification for absolute immunity. Although the court of appeals suggested that this supervisory role under the Sherman Act is inappropriate, 800 F.2d at 1507 (citing Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv. L. Rev. 435, 453 (1981)), *amicus* suggests that there is no warrant in the text or legislative history of the Act for forbidding such review as was performed by the district court in this case.

State action immunity is rooted solely in the doctrine of federalism and the need to respect state sovereignty. Unless immunity is necessary to effectuate federalism, then the judiciary has no reason to redact Congress' "carefully studied attempt to bring within the Act every person engaged in business whose activities might restrain or monopolize commercial intercourse." *Goldfarb v. Virginia State Bar*, 421 U.S. at 787-788 (quoting *United States v. Southeastern Underwriters Assn.*, 322 U.S. 533, 553 (1944)). Congress or the States remain free to preclude all antitrust scrutiny of peer review decisions if they should find absolute immunity necessary to achieve sound policy goals. But neither Congress nor the State of Oregon has, however, made the choice to immunize bad faith, anticompetitive abuse of the peer review process to limit competition or eliminate competitors. The district court's test, like both federal and state law, permits antitrust plaintiffs to succeed only if they can persuade the

to federalism values in permitting such review. In any event, because Oregon would permit a *state* jury in a *state* antitrust, or tort, case to engage in this inquiry, there can be no federalism bar to the same level of "second guessing"—if it be second guessing—by a federal jury in a federal antitrust case.

trier of fact that the conduct of a peer review committee was indeed based on a motive to exclude competition.

Goldfarb, Cantor, and Silver compel a grant of immunity commensurate with the limited nature of Oregon's policy to displace competition. The State has expressed no interest in shielding hospital staff members from competition by other qualified practitioners. Nor has the State expressed the judgment that restricting immunity to cases of good faith decisionmaking would systematically chill or disrupt the proper exercise of hospital peer review. Under these circumstances, it can hardly be said that the grant of absolute "state action" immunity by the Court of Appeals was necessary to achieve the state policy articulated in section 441.055(3)(d). Accordingly, "state action" immunity from the antitrust laws should appropriately extend in this case—as the district court extended it—only to peer review decisions made in good faith on the basis of medical competency. The claim of blanket, absolute antitrust immunity for hospital peer review decisions in Oregon must be rejected.

B. The State Of Oregon Does Not Actively Supervise Hospital Peer Review.

Even if respondents' anticompetitive abuse of the peer review process could be justified as furthering a clearly articulated policy of the State of Oregon—and *amicus* has demonstrated that it cannot—"state action" immunity would still be improper in this case because the State does not "actively supervise" hospital peer review decisions.

This Court has recognized that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 47 (1985). Thus, the requirement of active state supervision of private anticompetitive conduct is also es-

sential to striking the appropriate balance between the federalism interest in permitting state regulation and the Sherman Act goal of preventing anticompetitive economic conduct. In case after case, this Court has made clear that, at a minimum, "active supervision" means searching state scrutiny of the particular decisions of the private parties acting under cloak of state authority, to ensure that the delegated power is being exercised consistently with the purposes for which it was granted. *Town of Hallie v. City of Eau Claire*, 471 U.S. at 46; *Southern Motor Carriers*, 471 U.S. at 51 (state agencies "have and exercise ultimate authority and control over all intrastate rates" initially set by private parties); *Parker v. Brown*, 317 U.S. at 352 (state "adopts" privately set rate structure and "enforces it with penal sanctions").

California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97 (1980) ("*Midcal*"), sets forth the type of state participation in authorized anticompetitive conduct that constitutes "active supervision" sufficient to confer immunity. *Midcal* involved a California statute authorizing resale price maintenance for wine. Although finding a clearly articulated state purpose to permit private parties to set resale prices, this Court declined to find active supervision because

"[t]he State neither establishes prices nor reviews the reasonableness of the price schedules; nor does it regulate the terms of fair trade contracts. The State does not monitor market conditions or engage in any pointed reexamination of the program."

445 U.S. at 105-106 (internal quotation omitted). As this Court recently made clear in reaffirming the *Midcal* analysis in another case involving liquor resale price maintenance, 324 *Liquor Corp. v. Duffy*, "state action" immunity requires that an agency of state government supervise the *particular instances* of anticompetitive conduct by private parties acting pursuant to state author-

ity. — U.S. at —, 93 L.Ed.2d at 677-678. See also P. Areeda & D. Turner, *Antitrust Law* ¶ 213b, at 73 (1978) ("The key question here is whether the operative decisions about the challenged conduct are made by public authorities or by private parties themselves. When the latter is the case, there is insufficient public control to confer antitrust immunity.").

In the present case, the court of appeals found active supervision in a combination of three forms of alleged oversight by the State: (i) supervision of the establishment of hospital peer review procedures by Oregon's Health Division, Or. Rev. Stat. §§ 441.030, 441.055(3); (ii) required reporting to the BOME of decisions restricting or terminating privileges, Or. Rev. Stat. § 441.820(1); and (iii) judicial review. 800 F.2d at 1506. Close scrutiny reveals that *none* of these means of alleged oversight—either alone or in combination with the others—rises to the level of "active supervision" within the meaning of this Court's decisions.

Health Division Scrutiny. In no sense do sections 441.030 and 441.055(3) empower the Health Division to supervise the particular decisions of hospital peer review committees. Section 441.055(3) requires hospital governing boards to establish peer review committees, and to ensure that the procedures of the committees conform to applicable law. Review by the hospital board—a *private entity*—cannot substitute for active supervision by the State of Oregon. Section 441.030 authorizes the Health Division to deny, suspend, or revoke a hospital's license for failure to comply with various statutory and regulatory standards for hospitals. Although other statutory provisions authorize general supervision of hospital procedures, *e.g.*, Or. Rev. Stat. §§ 441.030(2), 441.150, 441.155, none of these provisions even implicitly invests the Health Division with official authority to review and overturn individual peer review decisions. On their face, these provisions do not authorize any form of administra-

tive review of hospital peer review. Nor is there any evidence that the Health Division has ever overturned, or even reviewed, the decision of a hospital peer review committee. Operational authority thus rests with the peer review committee and not with the Health Division.

BOME Scrutiny. That hospitals must report adverse peer review decisions to the BOME pursuant to Or. Rev. Stat. § 441.820 is irrelevant to the issue whether Oregon actively supervises peer review decisions. Neither the statutory nor the regulatory provisions setting forth the BOME's authority to regulate the practice of medicine even remotely suggest that the BOME possesses the authority to reverse, or even to review, hospital decisions denying or revoking privileges. Rather, the only plausible inference to be drawn from section 441.820 is that reporting is required in order to inform the BOME about instances of substandard medical practice so that the BOME can decide whether any official action, such as license revocation or suspension, is warranted. The BOME exercises no operational authority over peer review decisions.

Judicial Review. No court has ever held that decisions of hospital peer review committees in Oregon are subject to judicial review of any kind, much less the active supervision needed to confer state action immunity. The courts of Oregon have considered the issue of reviewability twice. In each instance, the court declined to resolve the question whether and to what extent hospital peer review decisions may be reviewed in the courts. *Straube v. Emanuel Lutheran Charity Board*, 287 Or. 375, 600 P.2d 381 (1979) (in banc); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975). Although *Huffaker* reserved the question whether any review of the substance of a peer review decision could be had in state court, *Straube*, the more recent case, suggested that a claimant would be at most entitled to challenge the fairness of peer review *procedures*. 600 P.2d at 384. Neither case

even hinted at the possibility of anything more than deferential ("arbitrary and capricious" or "substantial evidence") review. This uncertain and nonsubstantive review of peer review decisions falls far short of the type of active supervision necessary for state action immunity.

Under Oregon law, no organ of state authority ratifies, or even reviews, the peer review decision to ensure conformity with the state policy to promote sound medical practice. There is simply no "pointed reexamination" of peer review decisions. *Midcal*, 445 U.S. at 106. In short, the State of Oregon does not actively supervise individual peer review decisions in a manner sufficient to confer state action immunity upon the members of peer review committees.⁶ Accordingly, the decision of the court of appeals should be reversed for this reason as well.

II. RESOLUTION OF THE ANTITRUST ISSUES IN THIS CASE SHOULD BE INFORMED BY AN UNDERSTANDING OF THE POTENTIAL PROHEALTH AND PROCOMPETITIVE BENEFITS OF PEER REVIEW, BUT SHOULD ALSO ACKNOWLEDGE THE PARTICULAR ANTICOMPETITIVE RISKS OF UNSCRUTINIZED INTERPROFESSIONAL PEER REVIEW.

A. The Nature of Hospital Peer Review Requires Care In Defining The Scope Of State Action Immunity To Ensure That Prohealth And Procompetitive Activity Is Protected While Conduct Intended Solely To Limit Competition Is Not.

In challenging the decision of the Court of Appeals to provide state action immunity for bad faith hospital peer review decisions in Oregon, *amicus* does not mean to sug-

⁶ Indeed, it may be that the Oregon legislature was content to rely upon the judicial review provided by state and federal antitrust law to ensure that peer review served the purposes for which it is designed. The "good faith" immunity provided by statute was plainly intended to preserve liability for "bad faith" conduct.

gest that hospital peer review is inevitably anticompetitive in purpose and effect. To the contrary, in the judgment of *amicus*, properly conducted and supervised peer review can enhance both the quality of health services and competition in the market for provision of those services.

The term "peer review" refers to a broad range of related practices in the health care area. In general, the term denotes reliance on a group of professionals to fix standards for the quality, appropriateness, and reasonable cost of health care services. The practice had its genesis in cost-containment pressures from third-party payors such as insurance companies, Young, *A Brief History of Quality Assurance and Peer Review*, 8 Professional Psychology 9, 10 (1982), and this remains an important purpose of peer review. Peer review such as that at issue in the present case, however, is directed primarily at assuring the quality of health care. See Sechrest & Hoffman, *The Philosophical Underpinnings of Peer Review*, 8 Professional Psychology 14, 17 (1982) (describing potential of peer review to be "a centripetal force that would unite professionals in a genuinely collegial effort to promote responsible professional practice of the highest order"). This means of quality assurance has long been used by hospitals to ensure that staff physicians meet adequate standards of care. See generally Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case Western Res. L. Rev. 1117 (1986).

The use of peer review as a means of quality assurance for mental health professionals is also widespread. Because of the relative newness of this development, the efficacy of peer review as a means to enhance the quality of mental health care has not yet been thoroughly affirmed by empirical methods. See Cohen, *Research on Mental Health Quality Assurance*, in *Handbook of Quality Assurance in Mental Health* 65 (G. Stricker & A. Rodriguez eds. forthcoming); Sechrest & Rosenblatt,

Evaluating Peer Review, in *Handbook of Quality Assurance in Mental Health* 81. But policymakers—including the United States Congress—endorse peer review as a means to advance quality in the provision of mental health care. See Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* (providing immunity for good faith peer review decisions).

In most situations, peer review for quality assurance purposes will not raise serious risks of anticompetitive conduct, and will in fact promote competition. Because hospitals generally will be in competition with other hospitals, peer review to enhance the quality of medical care will improve the competitive position of a hospital by enhancing the services it offers. See Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1093 (“*Doctors and Hospitals*”). Competition on this level can also indirectly overcome the problem of general consumer ignorance about the relative quality of health care providers: “Because a hospital can obtain professional assistance in making technical decisions and must satisfy patients in a competitive environment, it can be viewed as a sophisticated and accountable agent of the ignorant consumer in making personnel decisions.” *Id.* at 1104. See also, Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 Case Western Res. L. Rev. at 1128.

In one situation, however, the hospital peer review process does present systemic risks of excluding competitors and limiting competition for reasons unrelated to the improvement of health care. The interprofessional or interdisciplinary nature of health care gives rise to special antitrust concerns. “A hospital’s policy on the admission of patients under the care of nonphysicians might easily reflect the staff physicians’ fear of competition over both price and therapeutic ideology.” Havighurst, *Doctors and Hospitals*, at 1113. Hospital peer review committees are typically in the control of physicians.

Physicians are frequently antagonistic to independent practice by psychologists and other health care providers who have degrees other than medical degrees, see *Virginia Academy of Clin. Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), and the pervasive practice has been to prevent these professions from obtaining hospital privileges, even when limited to activities within the scope of their professional licenses. See, e.g., *Position Statement on Hospital Privileges for Psychologists*, 128 Am. J. Psychiatry 1456 (1971) (setting forth official position of American Psychiatric Association); *Position Statement on Administration of Psychiatric Facilities*, 133 Am. J. Psychiatry 604 (1976) (same). Although this conduct will sometimes be rationalized on specious health-related grounds,⁷ often such arguments are pretexts, dressing up naked, unjustified efforts to restrict competition from alternative providers of mental health services or other health services. Courts have recognized this problem in numerous contexts.⁸

⁷ Typically such arguments will take the form of an attempt to define all treatment of mental health problems and other health problems as “medical” treatments. An official of the American Psychiatric Association has described the effects of the process as follows:

“Medical care becomes equated with health care. This brings psychiatry back into the mainstream of the medical establishment, because the equation of medical care with health care is the basis on which organized medicine claims the right to exert control over the total health care industry.”

Tension Rising Between Psychology, Psychiatry, Clinical Psychiatry News, November 1977 at 1 (summarizing remarks of director of membership services and studies division of American Psychiatric Association).

⁸ See, e.g., *Weiss v. New York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); *Shaw v. Hosp. Auth.*, 614 F.2d 946 (5th Cir. 1980), *cert. denied*, 449 U.S. 955 (1980).

Commentators have also perceived the potential for abuse. See Bersoff, *Hospital Privileges and the Antitrust Laws*, 38 Am. Psych. 1238, 1239 (1983); Dolan & Ralston, *Hospital Admitting Privileges and The Sherman Act*, 18 Houston L.R. 707, 728-729 (1981).

But these risks have not been addressed by the court of appeals or the parties in the present case. Given the prohealth and procompetitive potential of peer review, and the systemic risk of exclusionary practices in the interprofessional context, *amicus* suggests that it is crucial to exercise care in defining the scope of state action immunity. If a State has clearly articulated a policy that endorses purely exclusionary conduct by health care practitioners controlling peer review processes, then principles of federalism require this Court to respect the choice by recognizing an exemption from the antitrust laws. *Amicus* believes this situation will be rare or non-existent. All States—as well as the federal government—recognize the scientific and therapeutic validity of mental health care provided by psychologists.⁹ Most states, including Oregon, explicitly provide, through “freedom of choice” statutes, for direct recognition of psychologists for reimbursement purposes. Or. Rev. Stat. § 743.123.¹⁰ Because *amicus* is confident of the ability of psychology to be accepted in the legislatures, *amicus* believes that a properly limited state action immunity poses little risk of exempting from antitrust scrutiny the systematic efforts by physicians to exclude psychologists and other health professions from hospital privileges. If, however, state enactments authorizing peer review for purposes of improving health care are broadly understood as immunizing exclusions for the sole purpose of limiting competition—such as the exclusion at issue in this case—then there exists a significant risk of systematic exclusion of

⁹ All fifty states and the District of Columbia have certification or licensure laws authorizing psychologists to provide mental health care independently of medical supervision. Lahman, *Licensure Requirements for Psychologists: USA and Canada* (1978).

¹⁰ *E.g.*, Ark. Stat. Ann. § 66-3212.6 (1980); Md. Code Ann. art. 48A, § 490A (Supp. 1981); Miss. Code Ann. § 83-41-211 (Supp. 1981); N.Y. Ins. Law §§ 164.7-d, 221.5(e), 250.1 (Supp. 1981); Tenn. Code Ann. 56-7-108; Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Supp. 1979).

psychologists and other health professionals, in contravention of not only the free-market goals of the Sherman Act but also the explicit state and federal policies recognizing the validity of these professions.

B. These Principles Are Also Relevant To Deciding Broader Questions Of The Appropriate Antitrust Analysis For Hospital Peer Review Practices.

Should this Court find it necessary in the present case to reach the broader question of what standards of antitrust liability are appropriate for evaluating the hospital peer review process, *amicus* believes that the principles discussed in the foregoing section are highly relevant.

Some courts have provided a qualified immunity from antitrust liability for concerted activity by health care professionals where it is shown that an arguably anti-competitive decision was made for the purpose of promoting patient care. *E.g.*, *Wilk v. American Med. Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984), *on remand* — F.Supp. — (No. 76C3777, N.D. Ill., Aug. 27, 1987). Although *amicus* believes this position has much to recommend it, immunity of this kind is difficult to square with this Court's decision in *National Soc. of Professional Engineers v. United States*, 435 U.S. 679 (1978). In that case, the Court made clear that an anticompetitive restraint on bidding imposed by a professional organization was not immunized from antitrust scrutiny on the ground that the restraint was imposed for purposes of promoting public safety. 435 U.S. at 694-696. Nonetheless, *National Soc. of Professional Engineers* made clear that reasonable restraints on trade may survive antitrust scrutiny if they are ancillary to a legitimate purpose. *Id.* at 696 n.22. As applied to hospital peer review, individual peer review decisions will often be ancillary to pro-competitive purposes. *See Havighurst, Doctors and Hospitals*, 1984 Duke L.J. at 1093. Where, however, peer review decisions involve the denial by one profession of access to essential health care facilities for

members of other health care professions, then *amicus* suggests that a far more exacting antitrust scrutiny should be applied.

CONCLUSION

For the foregoing reasons, *amicus* submits that the judgment of the court of appeals should be reversed.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1987

TIMOTHY A. PATRICK,
Petitioner,

vs.

WILLIAM M. BURGET, et al.,

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

**JOINT BRIEF OF THE
ASSOCIATION OF AMERICAN
PHYSICIANS & SURGEONS, INC.
and the
SEMMELWEIS SOCIETY
AS AMICI CURIAE
IN SUPPORT OF PETITIONER**

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No. 86-1145

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1987

TIMOTHY A. PATRICK, PETITIONER

v.

WILLIAM M. BURGET, ET AL.

BRIEF FOR THE
ASSOCIATION OF AMERICAN PHYSICIANS
& SURGEONS, INC.
and the
SEMMELWEIS SOCIETY
AS AMICI CURIAE

INTEREST OF AMICI CURIAE

The Association of American Physicians and Surgeons, Inc. (AAPS) is a voluntary membership association formed in 1943 by private, practicing physicians and surgeons. The AAPS is incorporated under and by virtue of the corporation laws of the State of

Indiana, and its principal office is located in Burke, Virginia. The AAPS is the largest association with nationwide membership in the United States devoted exclusively to representing the interests of the private, practicing physicians and surgeons. The AAPS has members in every state and territory in the United States, and in the District of Columbia.

The use of the peer review system -- so prevalent in the health care industry -- for anticompetitive purposes has been a long-standing concern of the membership of the Association of American Physicians and Surgeons, Inc. Fundamentally an organization dedicated to encouraging competitive practices in the health care market, the AAPS has fought, for many years, for fairness in peer review.

The members of the Association of

American Physicians and Surgeons, Inc., being private, practicing physicians and surgeons, believes that quality as well as price fairness to the paying consumer of health care services is best achieved through vigorous competition. The members of the AAPS know only too well that the health care market, for many years, has been dominated by practices which are anticompetitive, and, consequently, those practices have denied market entry of practitioners, prohibited innovation and alternative methods of health care delivery, and blocked practices aimed at allowing prices for services to be dependent upon the competitive forces of the marketplace. Many of the anticompetitive ills in the health care marketplace emanate from the peer review setting such as is found in this case. The AAPS strongly believes that the

facts of this case serve to underscore the need for more vigorous antitrust application and enforcement within the peer review setting uniquely found in the health care industry. For, it is within the peer review setting (where competitors review the services of other competitors) absent any antitrust application and enforcement -- that decisions are routinely made in hospitals all across the country which affect the practices and livelihoods of health care providers and which emanate from anticompetition motives.

The Semmelweis Society is a non-profit corporation whose physician members throughout the United States share a common commitment with the Association of American Physicians & Surgeons, Inc., with respect to fair treatment of doctors in hospital peer review and privilege matters. The society

takes its name from the 19th century Hungarian physician, Ignaz Semmelweiss, who was vilified by his colleagues and superiors in the medical profession because of his strongly-held belief that physicians should wash their hands and use clean instruments before delivering babies and performing surgery. His life ended in disgrace for advocating views which ultimately led to the breakthroughs of Lister and Pasteur.

Semmelweis is remembered in history as the classic victim of abuse of power by fellow professionals to the detriment of society. The Semmelweis Society is dedicated to seeing that the peer review process in United States is not used to drive good doctors from the profession by cutting off their hospital privileges for reasons having nothing to do with improvement of the quality of medical care.

The Society is comprised of members who have been aggrieved by bad faith peer review. The Society believes that no government, state or federal, has envisioned a legislative mandate for peer review to be a cloak shielding anticompetitive conduct from antitrust liability. No government can fairly be said to intend protection for peer review when used to subvert the very purpose of such review and to function instead as a means for some doctors to destroy other doctors because of envy for the economic success of the latter. To permit an economic in-group to destroy the practice of a competent doctor is not in the interest of society and is certainly not what any State, including Oregon, has intended by requiring its hospitals to conduct peer review.

In short, this Court should not find a "state action" exemption to the antitrust

laws in this case when such a decision will sanction the use of the peer review process to create future Semmelweises in America. While Dr. Semmelweis had no remedy for the treatment he received at the hands of his peers in the 19th century, the "state action" doctrine of the antitrust laws of this land should not shield Dr. Patrick's oppressors who have used the peer review process in an attempt to destroy Dr. Patrick's practice in the community where he had chosen to live and work.

SUMMARY OF ARGUMENT

The bad faith use of the hospital peer review process to deprive a competent doctor of medical staff privileges at the only hospital in his community should not be exempt from antitrust liability. This Court has refused to tolerate manifestly anticompetitive conduct simply because the

health care industry and medical professionals are involved. In California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980), this Court adopted two-pronged test for determining when state regulation of private parties exempted them from federal antitrust laws: (1) the challenge restraint must be "clearly articulated and affirmatively expressed as state policy" and (2) the policy must be "actively supervised" by the State itself. The conduct of respondents in this case satisfies neither prong of Midcal.

ARGUMENT

THE STATE ACTION EXEMPTION TO THE FEDERAL ANTITRUST LAWS DOES NOT APPLY TO THE MALICIOUS, ANTICOMPETITIVE CONDUCT DEMONSTRATED IN THE RECORD OF THIS CASE

In the case under review, the United States Court of Appeals for the Ninth Circuit found that "There was substantial

evidence that the defendants acted in bad faith in the hospital's peer review process and in BOME [Oregon Board of Medical Examiners] proceedings." Patrick v. Burget, 800 F.2d 1498, 1503 (9th Cir. 1986) (brackets added). This characterization of the conduct of the defendants considerably understates the facts which are described briefly at the outset of the Patrick opinion. The record demonstrates that a group of doctors in Astoria, Oregon, utilized the peer review process and disciplinary proceedings before the Oregon Board of Medical Examiners (BOME) to accomplish anticompetitive ends which resulted ultimately in excluding Dr. Patrick from the practice of medicine in Astoria. The conduct in this case is premeditated, deliberate, and egregiously anticompetitive. The defendants' conduct represents precisely

the evil Congress had in mind when it enacted the antitrust laws with a treble damages remedy.

It should be observed that the nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act. Associated Press v. United States, 326 U.S. 1, 7 (1945). Nor is the public service aspect of professional practice controlling in determining whether section 1 includes professions. United States v. National Ass'n of Real Estate Boards, 339 U.S. 485, 489 (1950). Indeed, in the past, this Court has refused to tolerate manifestly anticompetitive conduct ". . . simply because the health care industry is involved." Jefferson Parish Hospital Dist. No. 2 v. Hyde, 466 U.S. 2, 25 n.42 (1984).

The respondents, who were the unsuccessful defendants in the trial court,

are private parties. They are not governmental entities of any kind. Yet they have invoked the state action doctrine to achieve immunity from Sherman Act liability. The Ninth Circuit has found, erroneously we believe, that the state action doctrine shields the defendants from antitrust liability. Your amici submit that state action immunity may not properly be found in this case. Furthermore, the conduct of the respondents in this case is so flagrantly anticompetitive that the Court should commence its consideration of this case with a healthy skepticism toward a technical defense which would leave Dr. Patrick without adequate remedy for the damages caused by defendants.

A. The State Action Doctrine Originated in Parker v. Brown and Has Been Refined into the Two-Pronged Test of Midcal Aluminum.

The state action doctrine finds its

origins in this Court's landmark decision of Parker v. Brown, 317 U.S. 341 (1943). In Parker, a raisin producer-packer sued California officials challenging a state program specifically designed to restrict competition among California raisin growers and thus maintain prices in the raisin market. The state program was, in effect, a cartel established for the benefit of California raisin producers and to the detriment of consumers nationally. The State Agricultural Prorate Advisory Commission authorized the organization of local cooperatives to develop marketing policies for the raisin crop. The Advisory Commission, appointed by the Governor, had to approve cooperative policies following public hearing. Thus, it was the state which created the machinery for establishing the prorate program and the state acting

through the Commission which adopted the program and which enforced it. 317 U.S. at 352.

In Parker, this Court held that the state regulatory program which restricted competition could not violate the Sherman Act because the Act was directed against "individual and not state action." Id. The raisin proration program in Parker was subject to extensive official oversight by the California Agricultural Prorate Advisory Commission which authorized the restriction of competition and which enforced the program. In California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 104 (1980), this Court observed with respect to the Parker decision that "[W]ithout such oversight, the result could have been different."

The Parker v. Brown opinion itself

expressly noted that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it or by declaring that their action is lawful" Id. at 351. In other words, the state must either run the regulatory program restricting competition itself or actively supervise it.

In Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), this Court held that the publication of a minimum-fee schedule by a county bar association and its enforcement by the State Bar violated section 1 of the Sherman Act. The schedule constituted a classic example of price fixing because the schedule and its enforcement mechanism created a price floor for legal services. Despite the fact that both bar associations claimed that the state action exemption enunciated in Parker immunized their actions

from antitrust liability, this Court held that the bar associations were not protected by the state action doctrine. This Court stated that "we need not inquire further into the state-action question because it cannot be fairly said that the State of Virginia through its Supreme Court Rules required the anticompetitive activities of either respondent. Id. at 790.

By way of contrast to Goldfarb, Bates v. State Bar of Arizona, 433 U.S. 350 (1977) involved an affirmative command of the Arizona Supreme Court that restricted advertising by lawyers and enforced that command with professional discipline. Since the restraint on competition in Bates was compelled by direction of the State acting as sovereign, this Court affirmed the Arizona Supreme Court's determination that the Sherman Act claim was barred by the

Parker v. Brown exemption. 433 U.S. at 360, 363.

This Court distinguished its decision in Cantor v. Detroit Edison Co., 428 U.S. 579 (1976) when it decided Bates. In Cantor, the defendant was an electric utility which distributed light bulbs to its residential customers without additional charge and included the costs of the light bulb program in its state-regulated utility rates. A retailer, who sold light bulbs, sued the utility in Cantor on a claim that the utility was using its monopoly power in the distribution of electricity to restrain competition in the sale of bulbs. This Court held in Cantor that the utility did not come within the state action exemption merely by embodying its challenged anticompetitive practices in a tariff approved by a state commission.

With respect to Cantor, this Court noted in Bates that "Cantor would have been an entirely different case if the claim had been directed against a public official or public agency, rather than against a private party. 433 U.S. at 361. This Court noted that, while in Cantor the State had no independent regulatory interest in the market for light bulbs, an exemption for the light bulb program was not essential to the State's regulation of utilities. Id. By way of contrast, regulation of activities of members of the bar is an important State interest since lawyers are essential to the administration of justice and have historically been officers of the Court. Finally, in Cantor, the state regulatory commission merely acquiesced in the light bulb program. Incorporation of the program into the tariff merely reflected a

conclusion that the utility was authorized to employ the practice if it so desired. 428 U.S. at 594 and n.31. The state did not enforce or supervise the light bulb program. Accordingly, the private activity of the electric utility was not immunized from antitrust liability as "state action."

In City of Lafayette v. Louisiana Power and Light Co., 435 U.S. 389, 410 (1978), this Court suggested, without deciding the issue, that it would be sufficient to obtain Parker immunity for a municipality to show that it had acted pursuant to a "clearly articulated and affirmatively expressed . . . state policy" that was "actively supervised" by the State. The plurality in City of Lafayette viewed this approach as desirable because it preserved to the States their freedom ". . . to administer state regulatory policies free of the inhibitions

of the federal antitrust laws without at the same time permitting purely parochial interests to disrupt the Nation's free-market goals." Id. at 415-416.

In California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980), this Court used the suggestion in City of Lafayette as its basis for affirming a state-court injunction prohibiting California officials from enforcing a statute requiring wine producers to establish resale price schedules. In Midcal, the City of Lafayette suggestion was adopted as this Court's two-pronged test for determining whether state regulation of private parties was shielded from the federal antitrust laws, the two prongs being as follows: (1) the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"

(445 U.S. at 105, quoting City of Lafayette v. Louisiana Power and Light Co., supra, 435 U.S. at 410); and (2) the policy must be actively supervised by the State itself. 445 U.S. at 105.

While the Midcal case involved California officials enforcing a state statute, the two-pronged test of Midcal was applied to private conduct in Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 57 (1985).

It is the position of your amici that the Court of Appeals for the Ninth Circuit misapplied both prongs of the Midcal test in reaching its conclusion that the respondents here were immunized from antitrust liability under the state action doctrine which originated in Parker v. Brown.

B. The Absence of a Clearly Articulated State Policy Fails To Satisfy the First Prong of the Midcal Test.

In Goldfarb v. Virginia State Bar, supra, 421 U.S. at 790, this Court said that "[t]he threshold inquiry in determining if an anticompetitive activity is state action of the type the Sherman Act was not meant to proscribe is whether the activity is required by the State acting as sovereign." Subsequent decisions of this Court have now indicated that the State need not compel the anticompetitive action, but merely permit it. The current formulation of this prong of this test has been stated as follows:

"In summary, we hold Midcal's two-pronged test applicable to private parties' claims of state action immunity. Moreover, a state policy that expressly permits, but does not compel, anticompetitive conduct may be 'clearly articulated' within the meaning of Midcal. Our holding today does not suggest, however, that compulsion is irrelevant. To the contrary, compulsion often is the best evidence that the

State has a clearly articulated and affirmatively expressed policy to displace competition. See Town of Hallie v. City of Eau Claire, ___ U.S., at ___, 105 S.Ct. at ___; 1 P. Areeda & D. Turner, Antitrust Law ¶ 212.5, p. 62 (Supp.1982) (compulsion is 'powerful evidence' of existence of state policy). Nevertheless, when other evidence conclusively shows that a State intends to adopt a permissive policy, the absence of compulsion should not prove fatal to a claim of Parker immunity." Southern Motor Carriers Rate Conference v. United States, *supra*, 471 U.S. at ___, 105 S.Ct. at 1729-1730 (footnote omitted; emphasis in original).

To satisfy the first prong of the Midcal test -- the requirement of a "clearly articulated" state policy -- the state policy has to be a state policy that says something about competition. As this Court expressed the point in Southern Motor Carriers Rate Conference v. United States, *supra*, 471 U.S. at 64: "As long as the State as sovereign clearly intends to displace competition in a particular field with a regulatory intent, the first prong of Midcal

Oregon statutes cited by the Ninth Circuit in its opinion, one is unable to find any expression whatsoever by Oregon as a sovereign that it intended to displace competition in any way, shape or form when it enacted statutes requiring hospital peer review or setting up the structure for professional discipline.

The fact that the peer review process may permit a panel of doctors to suspend or revoke a colleague's hospital privileges for perceived rendition of substandard medical care does not demonstrate that the State of Oregon intended to replace competition with regulation in the market for physicians' services. The ostensible purpose of peer review (and professional discipline) is to insure quality medical care. From the fact that honest peer review may have the incidental effect of reducing competition,

one cannot make the leap of logic which the Ninth Circuit has made to the conclusion that the State of Oregon has supplanted competition with regulation.

The expressed purpose of Oregon peer review is to reduce morbidity and to improve patient care. Or. Rev. Stat. §§ 441.030, 441.055(3)(c) & (d). The aims of reducing morbidity and improving patient care articulate nothing about displacing competition among doctors within the State of Oregon. After the requirement of peer review, doctors were no more and no less free to compete in the marketplace. Peer review and professional discipline for substandard performance are, and should be, truly competition neutral.

The anticompetitive circumstances found in cases where this Court has found a "clearly articulated State policy" to

displace competition are sharply distinguishable from the Oregon peer review and professional discipline structure under review here. In Town of Hallie v. City of Eau Claire, 471 U.S. at 42, this Court held that Wisconsin statutes clearly contemplated that "a city may engage in anticompetitive conduct. Such conduct is a foreseeable result of empowering the City to refuse to serve unannexed areas." State statutes authorized the City to provide sewage services and to determine the areas to be served. This Court stated that "We think it clear that anticompetitive effects logically would result from this broad authority to regulate." Id.

By way of contrast, it is not clear that anticompetitive effects logically would result from the authority conferred for peer review or professional discipline.

a foreseeable result of empowering the City to refuse to serve unannexed areas." State statutes authorized the City to provide sewage services and to determine the areas to be served. This Court stated that "We think it clear that anticompetitive effects logically would result from this broad authority to regulate." Id.

By way of contrast, it is not clear that anticompetitive effects logically would result from the authority conferred for peer review or professional discipline. Anticompetitive conduct, such as the defendants pursued in this case, was hardly a foreseeable result of empowering the medical staff of Columbia Memorial Hospital with authority to conduct peer review. It is hardly foreseeable that pursuit of a reduction in morbidity and improvements of patient care will be anticompetitive. It

takes a tremendous leap of logic to conclude that the State of Oregon had a "clearly articulated policy" which countenanced use of the peer review process as a means of monopolizing the right to practice medicine in a community. The foreseeability of some doctors, such as the respondents here, subverting the peer review process to accomplish anticompetitive ends does not demonstrate that the anticompetitive results here logically resulted from the broad authority to regulate in the sense intended by this Court in Town of Hallie. The distinction is that here the State of Oregon must find the conduct of respondents reprehensible (and not what it intended), whereas in Town of Hallie a refusal to serve unannexed areas was clearly contemplated by the broad authority to regulate conferred by the State of Wisconsin there.

Likewise in Southern Motor Carriers Rate Conference v. United States, *supra*, 471 U.S. at 63-64, this Court found that the Mississippi Legislature had made clear its intent that intrastate rates would be determined by a regulatory agency, rather than by the market. The state commission involved actively encouraged collective ratemaking among common carriers. Hence the anticompetitive ratemaking practices undertaken by private motor carriers were authorized and encouraged by state policy (although not compelled). On the other hand, no anticompetitive conduct was encouraged by the Oregon statutes which set up the peer review and professional discipline structures. There was no "clearly articulated" State policy which authorized or permitted the egregious anticompetitive acts pursued by the

respondent for their own ends.

In New Motor Vehicle Board v. Orrin W. Fox Co., 439 U.S. 96, 109 (1978), this Court found no express intent to displace the antitrust laws but found "a system of regulation, clearly articulated and affirmatively expressed, designed to displace unfettered business freedom in the matter of the establishment and relocation of automobile dealerships." This regulatory scheme inherently placed the anticompetitive activity involved outside the reach of the antitrust laws under the Parker "state action" exemption. This case is again distinguishable from New Motor Vehicle Board because Oregon has nowhere "clearly articulated and affirmatively expressed" a policy in its peer review statutes to displace competition among doctors. If the exceptional circumstances of this case are

placed to one side, there is nothing inherent in Oregon peer review or professional discipline that compels or permits the type of egregious anticompetitive conduct which Dr. Patrick proved in the district court.

C. The Absence of a Active State Supervision Fails To Satisfy the Second Prong of the Midcal Test.

In Midcal, it was held that not only must the challenged restraint be "one clearly articulated and affirmatively expressed as state policy" but also the policy authorizing or permitting the restraint must be actively supervised by the State itself. 445 U.S. at 105. Hence petitioner Patrick may prevail in this Court if he is successful on either prong of Midcal, whereas respondents must prevail by an adequate showing on both prongs of that decision.

With respect to the second prong of Midcal, it should be noted that there was active supervision in Parker v. Brown because the marketing plan proposed by California raisin growers did not take effect unless and until a state board approved it. The key question under the second prong of Midcal "is whether the operative decisions about the challenged conduct are made by the public authorities or by the private parties themselves. When the latter is the case, there is insufficient public control to confer antitrust immunity." 1 P. Areeda & D. Turner, Antitrust Law ¶ 213b, at 73 (1978). This Court expressed this point in similar words in Town of Hallie v. City of Eau Claire, supra, 471 U.S. at 47:

" . . . Where a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests,

rather than the governmental interests of the State."

The second prong of the Midcal test is essential in cases involving private parties because "the requirement of active state supervision serves an evidentiary function: it is one way of ensuring that the actor is engaging in the challenged conduct pursuant to state policy." Id. at 46. On the record before the Court, respondents are unable to demonstrate that there was "active supervision" by the State of Oregon which would make their actions fairly attributable to the State. "State action" immunity from federal antitrust laws is available only if the state provides, by one means or another, sufficient supervision to see that private parties' exercise of discretion in particular cases furthers a state regulatory policy.

This Court's decisions have required

that the state give final approval to the anticompetitive conduct of private parties because that conduct become immunized "state action." In other words, the State must exercise ultimate control over the anticompetitive restraint before the second prong of Midcal has been satisfied. For example, in Parker v. Brown, supra, there was state action because the proposed marketing plan of California raisin growers did not take effect unless and until it was approved by a state board. Similarly, in Southern Motor Carriers, supra, 471 U.S. at 51, this Court took particular note of the fact that the State public service commissions "have and exercise ultimate authority and control over all intrastate rates." Most recently, in 324 Liquor Corp. v. Duffy, ___ U.S. ___, 107 S.Ct. 720, 723 (1987), this Court found that New York's

liquor pricing policy did not satisfy the second prong of the Midcal test because the system was "not actively supervised by the State." As this Court found in Midcal, it also found in 324 Liqueur Corp. that the State simply authorized price setting and then enforced the prices established by private parties. New York neither established prices nor reviewed the reasonableness of the price schedules. Nor did New York monitor market conditions or engage in any reexamination of the program. 107 S.Ct. at 725-726. In short, this Court concluded that "The state has displaced competition among liquor retailers without substituting an adequate system of regulation." Id. at 726. Without an adequate system of regulation, "[t]he national policy in favor of competition cannot be thwarted by casting such a gauzy

cloak of state involvement over what is essentially a private . . . arrangement." Midcal, supra, 445 U.S. at 106, 100 S.Ct. at 943.

Even if one assumes for the purposes of argument that Oregon has displaced competition through its peer review statutes, respondents' case becomes impaled on the second prong of Midcal. There is no showing in the record that Oregon has retained "ultimate authority and control" Southern Motor Carriers, supra, 471 U.S. at 51) or has established "an adequate system of regulation" (324 Liqueur Corp, supra, 107 S.Ct. at 726) over medical staff peer review decisions or privilege decisions by hospitals.

The Ninth Circuit opinion states that "the combination of internal review by the hospitals, review by the BOME, and review by

the courts constitutes adequate supervision." Pet. for Cert., App. 11a; Patrick v. Burget, supra, 800 F.2d at 1506. When any of these three procedures (or indeed all three taken together) are subject to critical scrutiny, it clearly appears that the Ninth Circuit erred in finding the "active supervision" by the State of Oregon necessary to satisfy to the second prong of the Midcal test. The record does not establish that any of these three procedures involves review by a state official or agency of any private decision of a peer review body regarding hospital privileges. Furthermore, in the absence of any "clearly articulated policy" disfavoring competition, there could not be any meaningful review to determine whether private hospital peer review bodies were carrying out state policy.

As a condition of maintaining their licenses, hospitals in the State of Oregon must insure that procedures exist for granting or restricting privileges of the medical staff and that the medical staff is organized in such a manner as to review effectively one another's professional practices at the facility to reduce morbidity and to improve patient care. See Or.Rev.Stat. §§ 441.030, 441.055 (c) & (d). The mere existence of this statutory scheme tells us nothing about "active supervision" by the State. More significant from the standpoint of oversight are the statutes which permit the Oregon Health Division to deny, suspend, revoke a health care facility's license for failure to comply with this requirement. Or. Rev. Stat. § 441.030(2). But the Health Division oversight responsibility for insuring that

Oregon hospitals have peer review procedures is not "active supervision" for purposes of the second prong of Midcal. Ensuring the existence of peer review is not the same as the power to supervise the peer review process. There is no evidence that the Health Division has any power to overturn any peer review decision, no matter how far it departs from the State's policy (assuming, of course, the State has any policy as regards competition). Mandating the existence of the peer review is not "active supervision" where, as here, the decisions of private parties have been found by a jury to violate the antitrust trust laws -- and the State of Oregon has played no part in approving or otherwise reviewing those decisions before they became operative upon Dr. Patrick.

Similarly, the fact that Oregon

hospitals are required by statute to notify the BOME promptly of a decision to terminate privileges (see Or. Rev. Stat. § 441.820) does not demonstrate "active supervision" for purposes of the "state action" doctrine. Beyond receiving the report and passively keeping that report in its files, there is no showing in the record before this Court that BOME has any authority to change the result of any peer review decision made by private parties on the governing boards of hospitals. The important point with respect to the notification requirement is that it does not occasion any intervention by the State of Oregon into the peer review process. A doctor aggrieved by an unfair and anticompetitive peer review decision cannot look to BOME to set it right. While BOME may determine to take additional action on its own to suspend or revoke the

physician's license to practice medicine (Ore.Rev.Stat § 677.190), such action is not review or supervision of the hospital peer review process. There is no evidence in the record that Oregon's Board of Medical Examiners (BOME) has any statutory authority to correct, review, or overturn the decision of the hospital peer review body. Absent such statutory authority, respondents have not demonstrated that BOME in practice undertakes any review or that it has ever asserted any authority to set aside a hospital's action in a peer review proceeding resulting in termination of privileges.

Finally, the record does not establish that Oregon "actively supervises" hospital peer review decisions terminating a physician's staff privileges through judicial review in its courts. There is no

Oregon statute which establishes a right to judicial review in any form. Moreover, the Oregon cases have never conclusively decided that review is available as a matter of common law right. In Straube v. Emmanuel Lutheran Charity Board, 287 Or. 375, 383, 600 P.2d 381, 386 (1979), cert. denied, 445 U.S. 966 (1980) the Oregon Supreme Court assumed but did not decide the plaintiff was entitled to some type of judicial review of a hospital decision to suspend his staff privileges. Earlier in Huffaker v. Bailey, 273 Or. 273, 275, 540 P.2d 1398, 1399 (1975), the Oregon Supreme Court has also declined to decide the "interesting questions" of whether the decisions of a hospital's governing board were subject to judicial review and whether mandamus was the proper method of review. With the question being unresolved as to whether there is any

review whatsoever of hospital privilege decisions, it can hardly be stated that Oregon undertakes "active supervision" through its courts.

Even if Oregon did provide a judicial mechanism for review of hospital privilege decisions, there is no Oregon standard against which such decisions might be judged. In Huffaker, the Oregon Supreme Court indicated that it would not overturn a hospital decision "made in good faith and supported by an adequate factual basis." 273 Or. at 384, 540 P.2d at 1401. In the most recent case of Straube, the Oregon Supreme Court stated that an Oregon court should not decide the merits of a doctor's dismissal and that "[i]t would be unwise for a court to do more than make sure that some sort of reasonable procedure was afforded and that there was evidence from which it

could be found that plaintiff's conduct posed a threat to patient care." 287 Or. at 384, 600 P.2d at 386. It is obvious from such statements in the only two Oregon Supreme Court opinions that Oregon defers to private decisionmaking rather than enforcing a state policy promulgated by institutions of state government. Such deference is hardly the "active supervision" contemplated by this Court under the second prong of the Midcal test.

There is a serious question as to whether such deferential review on an ad hoc basis can ever be "active supervision" of a State policy. Ratification of private decisions after the fact does not manifest "active supervision" of a state policy, especially where the State has not articulated its standard of review. Mere deference to a hospital decision supported

by "any evidence" does not serve to make the actions of private parties actions of the State itself.

The Ninth Circuit's decision in this case would exempt the private conduct here involved from the purview of federal antitrust laws even though no state official considered or reviewed the conduct in any manner whatsoever. Such a result cannot be squared with the federal antitrust laws because it would frustrate "the national policy in favor of competition" (*Midcal*, *supra*, 445 U.S. at 106) without furthering any clearly articulated policy of the State of Oregon.

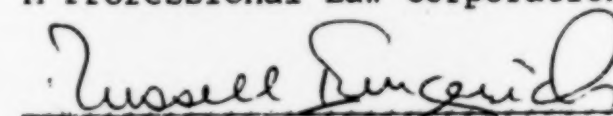
CONCLUSION

For the foregoing reasons, your amici urge that this Court reverse the decision of the United States Court of Appeals for the Ninth Circuit now under review.

Dated: November 25, 1987.

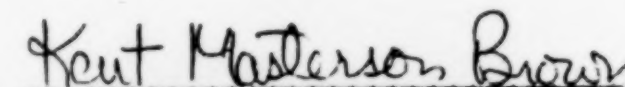
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BRIEF

Supreme Court, U.S.
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In The
Supreme Court of the United States

October Term, 1987

—o—
TIMOTHY A. PATRICK,

Petitioner,

vs.

WILLIAM M. BURGET, *et al.*,

Respondents.

—o—
On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit
—o—

**BRIEF FOR THE BOARD OF MEDICAL QUALITY
ASSURANCE OF THE STATE OF CALIFORNIA,
THE CALIFORNIA MEDICAL ASSOCIATION AND
THE CALIFORNIA ASSOCIATION OF HOSPITALS
AND HEALTH SYSTEMS AS AMICI CURIAE
IN SUPPORT OF RESPONDENTS**

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No. 86-1145

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THE CALIFORNIA MEDICAL ASSOCIATION AND
THE CALIFORNIA ASSOCIATION OF HOSPITALS
AND HEALTH SYSTEMS AS AMICI CURIAE
IN SUPPORT OF RESPONDENTS**

With consent of the parties, the Board of Medical Quality Assurance of the State of California (BMQA), the California Medical Association (CMA) and the California Association of Hospitals and Health Systems (CAHHS) respectfully submit this brief as amici curiae in support of respondents.

INTEREST OF AMICI CURIAE

BMQA is an agency of the State of California, consisting of 19 members, seven of whom are public members.

The Board consists of three divisions: a Division of Medical Quality, which enforces and administers the disciplinary and criminal provisions of California's Medical Practice Act, and reviews the quality of medical practice carried out by licensed physicians; a Division of Licensing, which issues licenses and certificates under the Board's jurisdiction, examines applicants for licensure as physicians, and approves educational programs; and a Division of Allied Health Professions, which has responsibility for the activities of non-physician licentiates under the jurisdiction of the Board and the discipline of such licentiates. BMQA assumed the responsibilities previously assigned to California's Board of Medical Examiners, the predecessor agency, as well as additional responsibilities which are further described in this brief.

CMA represents approximately 30,000 physicians in the state of California, who constitute the majority of physicians actively engaged in peer review functions, particularly in California hospitals. CAHHS represents approximately 500 California hospitals, including non-profit, religious, proprietary and county hospitals. For more than 50 years, CMA and CHA have been directly involved in the evolution of the medical peer review system in California. By peer review system, we refer not only to credentialing and administering corrective action to errant physicians but also to the continuing process of self-audit and evaluation in which the medical community is engaged on a daily basis. Simply stated, California and other states have incorporated peer review into state regulatory systems as the first line of defense in their ongoing program to maintain and improve the quality of health care services.

We believe it is important for the court to understand the California experience with peer review because its development in California is typical of developments in substantially all other states, differing only as to the degree. Peer review has developed more rapidly and completely in California and has been more clearly documented due to litigation and legislative action that has accompanied most major changes. Peer review will continue to evolve in California and other states to meet the increasing pressures on the health care system to provide even higher quality health care at an affordable cost. It places an overwhelming responsibility on physicians and their colleagues in the medical community to assure a continued balance among the rights of individual physicians, patients and the funders of health care.

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SUMMARY OF ARGUMENT

The purposes of this brief are to demonstrate that the peer review process is state mandated and to identify the unique and essential characteristics of that process as it has developed in the past 50 years.

Through historical exposition, this brief will show:

1. Medical peer review in the hospital or medical institution setting constitutes state action. It has been mandated through a series of evolutionary steps by all branches of government, including judicial, legislative and executive. The states have not and realistically cannot provide a program of direct control and have, accordingly, incorporated peer review into their regulatory programs. There is no available substitute for peer review.

2. Peer review is performed by volunteers acting through a unique administrative structure known as the Hospital Organized Medical Staff, which is supported by the hospital governing board. It requires highly sensitive balancing of interests and poses high risks to the individual participants. Those risks have been recognized by both the state legislature and the judiciary, both of which have taken responsive action to protect the integrity and fairness of the peer review process.
3. With full knowledge and understanding by state authorities, participants in peer review are free of the threat of antitrust sanctions at both the state and the federal levels. We fear that many, possibly most, physicians will be unwilling to continue their voluntary participation in the peer review process if they face liability under the federal antitrust laws for their participation. There is no one available to fill the gap their absence would create.

I. INTRODUCTION

This court has been asked to determine whether participants in peer review activities carried on in an Oregon hospital are entitled to protection of the "state action" exemption to Sherman Act suits. The facts presented to the court describe a small professional community in a small city, served by a single hospital. This singular situation affords minimal basis for defining the relationship of private sector peer review activity to state regulation of physicians, hospitals, and systems of health care. The California experience which is described in this brief provides a broader perspective, pertinent to the court's consideration for these reasons:

A. Conceptually, Oregon's statutes and the California legislative scheme serve identical purposes. Each state has provided that medical staff peer review

shall be the first line of defense in the state's scheme for protecting the quality of care.

B. These state statutes follow an evolutionary process. California's experience, reflecting a more mature state regulatory scheme and a more extensive body of case law, provides an instructive model for assessing the integration of private sector and public sector activities, particularly in determining underlying policy.

It would be unfortunate if continuing efforts to build on the peer review process in developing better regulation of health care throughout the nation were impaired by a holding reflecting examination of a single example of the peer review process.

II. LEGAL DISCUSSION

A. Origin Of Peer Review

Any discussion of state action incorporating peer review mechanisms into regulatory schemes must acknowledge the source of these mechanisms. Peer review is a fundamental professional activity. In medicine, peer review is unique because it is a routine, day-to-day activity performed by volunteers, particularly as members of hospital medical staffs.

The peer review mechanism predates the organized medical staff. Some 50 years ago, hospitals in California and other states recognized that licensure alone was an inadequate basis for the granting of staff privileges. Hospitals therefore looked to county medical societies to review physicians who were new to the community by depending upon the medical society's own credentialing process. By the late 1950's litigation or threats of litigation by individual physicians challenging their exclusion or ter-

mination from medical staffs began to surface. In decisions such as *Wyatt v. Tahoe Forest Hospital District*, 174 Cal.App.2d 709, 345 P.2d 93 (1959), the courts began to make it clear that hospitals had a direct responsibility for establishing and applying standards and rules for staff membership. In 1962, the California Supreme Court decided *Willis v. Santa Ana etc. Hospital Association*, 58 Cal.2d 806, 26 Cal.Rptr. 640, 376 P.2d 568. The court ruled that the California antitrust law, known as the Cartwright Act, did not apply to an action involving admission to a medical staff because the Act did not apply to the professions. In this pre-*Goldfarb* era, it was also assumed that federal antitrust laws were similarly inapplicable. However, the court held there was a common law right of action for unwarranted exclusion from the medical staff. These developments caused the legislature to begin focusing upon the organized medical staff, which existed primarily to provide peer review mechanisms.

In 1965, the California Legislature added Business and Professions Code section 2392.5, now section 2282, to California's Medical Practice Act. Section 2282 makes it unprofessional conduct to practice in a hospital having five or more physicians or surgeons on the medical staff unless the hospital has rules established by the board of directors providing for the organization of a formal medical staff. In the same session, the Legislature also added section 2212.5 to the Business and Professions Code, which has since been revised and renumbered as section 2286. Originally applicable to the Board of Medical Examiners, the statute now refers to the Division of Medical Quality of the Board of Medical Quality Assurance (BMQA), and provides that the Division of Medical Quality may inspect

hospitals and require reports and inspect medical staff and patient records to determine compliance with the requirements for maintenance of an organized medical staff. Thus, it was more than twenty years ago that California required the maintenance of medical staff peer review mechanisms and assigned regulatory authority to the medical licensing board.

B. Protecting The Peer Review Process

Professional peer review, particularly in the hospital setting, is carried on by *volunteers* discharging a professional responsibility. The danger of suit and personal liability has always been the greatest threat to the survival of this resource. As hospitals sought to cope with their newly identified responsibility to meet legal standards governing the denial or withdrawal of privileges, and as county medical societies became increasingly reluctant to engage in peer review activities, the Legislature recognized the need to grant statutory protections to the peer review process. The first step was taken in 1961, when Civil Code section 43.7 was enacted, providing conditional immunity for members of professional staff or professional society committees formed to maintain professional standards or to review the quality of medical services. In 1968 the Legislature enacted California Evidence Code section 1157, protecting against the discovery of medical staff or medical society committee records, except in litigation challenging the peer review decision. As was observed in *Matchett v. Superior Court*, 40 Cal.App.3d 623, 115 Cal.Rptr. 317 (1974) "Section 1157 represents a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiff's access to evidence." Having established peer review as the

basic mechanism for overseeing and regulating the quality of care, the legislature deliberately and significantly protected peer review and the volunteers participating in it from suit or other legal entanglement extrinsic to the process itself.

C. Statutory Integration Of Peer Review And Public Processes

In 1975, California directly integrated the peer review process already required in all hospitals with the comprehensive statutory scheme licensing and regulating medical practitioners. There can be no suggestion that this was an attempt to cast "the gauzy cloak of state involvement" over hospitals and physicians pursuing their own purposes. In a fundamental revamping of the entire medical licensing and regulatory system, the legislature linked functions assigned to the hospital and its medical staff with responsibilities placed upon the new Board of Medical Quality Assurance (BMQA) created in the same legislation. This was done when the California Legislature was meeting in special session called specifically to address the professional liability crises.

The enactment of the Medical Injury Compensation Reform Act of 1975 ("MICRA"), a comprehensive tort reform package, in that special session is very well remembered. It is generally recognized that MICRA brought California's professional liability insurance problem under control, measuring the present cost and availability of medical malpractice insurance in California against cost and availability in numerous other urban states. What tends to be forgotten is that MICRA was only a part of the legislative package contained in AB1XX, adopted in that

special session. As then-Assemblyman Keene, the principal author, has pointed out in his frequently quoted article "California's Medical Malpractice Crisis" appearing in *A Legislator's Guide to the Medical Malpractice Issue* (1976), AB1XX also addressed the problem of "bad doctors."

One of the principal components of the new legislative scheme was the enactment of Business and Professions Code section 805, requiring the reporting of medical staff disciplinary actions to BMQA. Saying that "Health Quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits," Assemblyman (now Senator) Keene notes that the medical quality control provisions of the bill established "... a central file reporting mechanism to assure that doctors who are successfully sued or are disciplined by hospitals are reported to the Board and are immediately investigated [by BMQA] to determine their competency." This cornerstone provision in California's legislative scheme subsequently was the model for similar legislation in other states. Indeed, the Health Care Quality Improvement Act which Congress adopted in 1986 largely replicates the California legislative scheme.

D. California Legislation Since 1975

By itself, the reporting requirement has been effective in identifying physicians who should be evaluated for discipline by the state. However, there were problems. The fear of suit, both for making the required section 805 report and for taking the underlying action generating the report, was foremost. Hospitals and medical staffs were

aware of penalties for failure to file section 805 reports, but they were more afraid of suits which formal discipline and reports might generate. Suits brought on common law theories were not infrequent and often sought punitive damages (uninsurable in California) as well as compensable damages from hospitals and individuals involved in the peer review process.

In 1985, a California Supreme Court decision placed another weapon in the arsenal available to potential plaintiffs. In *Cianci v. Superior Court*, 40 Cal.3d 903, 221 Cal. Rptr. 575, 710 P.2d 375, applying *Goldfarb* and *National Soc. of Prof. Engineers*, the California Supreme Court ruled that the Cartwright Act extends to the professions, and specifically to the medical profession. BMQA regarded reports made to it by hospitals pursuant to Section 805 as the most effective means at its disposal for identifying physicians for disciplinary or rehabilitative action. In 1986, determining that both effective peer review and subsequent reporting to BMQA were being impaired by the growing threat of retaliatory suit, BMQA went to the Legislature. Senate Bill 1888, sponsored by BMQA, further integrated private sector and BMQA processes, extended reporting requirements to additional entities, and provided new protections for those who complied. Senate Bill 1888 (Chapter 1274, Statutes of 1986) established immunity for making the reports required by Section 805. As additional incentive for making these reports, it also provided new immunity for actions undertaken in the peer review process when reported to BMQA. Non-economic damages would not be recoverable in a subsequent suit against the hospital or peer review body if the required report was made and if there was no intent to cause intentional in-

jury or deprivation of rights. Reporting requirements were extended to medical, psychological, dental or podiatric professional societies. BMQA and the legislature recognized that there are physicians who practice entirely outside of other organized peer review systems because they have no hospital privileges and because they avoid participation in third-party reimbursement programs. Except for BMQA itself, the medical society provides the only resource available to the public for the consideration of complaints, which often arise in the context of fee review. By building the medical society into the BMQA substructure through required reporting, the legislature enhanced BMQA opportunities for detection or review of aberrant practice.

Senate Bill 1888 also provided BMQA with the fruits of the peer review process. Previously, BMQA received only limited information in the Section 805 report itself. Because of Evidence Code Section 1157, peer review records were unavailable to BMQA when pursuing individual investigations and could be inspected only for the limited purposes described in Business & Professions Code Section 2286, *supra*. Senate Bill 1888 gave BMQA access to statements of charges, documents, medical charts, exhibits in evidence and opinions, findings, or conclusions garnered in the peer review proceeding. Thus, BMQA obtained the benefits of the work and expertise applied in the peer review process, greatly expanding BMQA's fact finding and enforcement capability.

In 1987, the impetus attributable to the passage of Senate Bill 1888 continued with the enactment of Senate Bill 1620 (Chapter 1044, Statutes of 1987), also intro-

duced at the request of BMQA. SB 1620 repealed Business & Professions Code Section 805 and reenacted substantially revised provisions. The definition of reportable events was revised and significantly expanded to include contract terminations and other circumstances which may warrant BMQA attention when undertaken for a medical disciplinary cause or reason. Medical staffs are required to report summary suspension of privileges even before usual peer review processes are completed. The reporting requirement was extended to organized committees of entities consisting of or employing twenty-five or more physicians. All entities required to report to BMQA pursuant to Section 805 are now required to make supplementary reports after the terms or conditions imposed in the peer review process are satisfied by the practitioner. They now must also serve the affected practitioner with copies of all reports made pursuant to Section 805. In the same legislative session, Assembly Bill 2249 (Chapter 721, Statutes of 1987) was passed, amending Section 805.5 of the Business & Professions Code. Section 805.5, in place since 1979, requires hospitals to query BMQA with respect to information reported pursuant to Section 805 when appointing or reappointing medical staff members. The 1987 amendment expedites that process. By this device, California uses the BMQA apparatus to further integrate the peer review process in all hospitals.

Realistically, to require BMQA to pass upon every peer review decision in order to meet the supervision requirement would place an impossible burden on state government. Moreover, peer review activities interpret and apply different requirements for separate purposes. This was emphasized in the recent decision of the Cali-

fornia Court of Appeal, First Appellate District, in *Bonner v. Sisters of Providence*, 194 Cal.App.3d 437, 239 Cal. Rptr. 530 (1987). In that decision, the court defined the respective functions of BMQA and the hospital board.

"Hospital bylaws are required to provide that the medical staff 'establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform . . . procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at . . . least every two years' after appointment to the staff. (Cal.Admin. Code, tit. 22, sec. 70701, subd. (1) (7).) The medical staff is responsible to the hospital for the adequacy and quality of the medical care rendered to patients in the hospital. (Cal.Admin. Code, tit. 22, sec. 70703, subd. (a).) Clinical privileges are hospital specific. So long as there is a rational basis for the medical staff's requirements for clinical privileges, a hospital may make its requirements as stringent as it deems reasonably necessary to assure adequate patient care. (*Hay v. Scripps Memorial Hospital* (1986) 183 Cal.App.3d 753, 763 [228 Cal.Rptr. 413].) Hospital review boards do not review their physicians' conduct to determine whether they should be licensed to practice medicine in California. Their review is for the purpose of determining whether the medical staff members provide the quality of care the hospital requires." (*Id.*, at p.446.)

It would be both impractical and counter-productive to require BMQA to second-guess the decisions of peer review bodies. On the other hand, it is extremely useful to achieve sufficient merger between private and public processes to ensure that peer review occurs, that information flows freely to BMQA, and that BMQA benefits from the peer review body's expertise. It is this very linkage

between medical staff and BMQA processes which causes physicians involved in medical staff disciplinary matters to use every threat or weapon at their command to avoid adverse action at the medical staff level. For example, Dr. Bonner, who had obtained a trial court order reinstating his privileges until the Court of Appeal decided otherwise, also had filed a widely-publicized suit seeking substantial damages from the hospital and participants in the peer review process. Anti-trust suits, with provision for treble damages and award of attorney's fees plus staggering defense costs, are a particularly fearsome weapon. The protections which have been established for the private sector portion of this integrated process are characteristic of the protections extended to governmental actions accomplished for the benefit of the public and not for the benefit of the individuals who may be involved.

E. The Legal Responsibility Of The Hospital Governing Board And Medical Staff For Patient Quality Care

Since the case of *Elam v. College Park Hospital*, 132 Cal.App.3d 332, 183 Cal.Rptr. 156 (1982) California hospitals may be held liable for the medical malpractice of a medical staff member under a theory of "corporate negligence," if the hospital failed to ensure the staff member's competency through careful selection and review. A hospital can only carry out its duty to evaluate the competency of its staff and the quality of medical treatment through appropriate peer reviews. Absent certain guarantees of immunity for peer review participants, a hospital and its medical staff will predictably have difficulty recruiting physicians to serve on peer review committees and perform these functions.

The *Elam* Court succinctly summarized the legal responsibility of the hospital and the hospital governing board for maintaining quality of care through effective peer review.

That Court states on pages 341-342:

"Our conclusion accords with statutory authority recognizing hospital accountability for the quality of medical care provided and the competency of its medical staff. Health and Safety Code section 1250, subdivisions (a), (b), (f) and (g) define hospital in pertinent part as 'a health facility having a duly constituted governing body with overall administrative and professional responsibility . . .' More specifically, section 32125 confers upon the board of directors of a public hospital the responsibility of its operation in accordance with 'the best interests of the public health,' including the power to 'make and enforce all rules, regulations and by-laws necessary for the administration, government, protection and maintenance' of the hospital, and to insure that minimum standards of operation required by statute are followed. Sections 32128 and Business and Professions code section 2392.5 set forth, at least by implication, the scope of public and private hospitals' duty of care. Regarding staff selection, although the medical staff is to be 'self-governing,' a hospital must provide procedure for selection and reappointment of the medical staff in accordance with JCAH standards, implying investigation of competency for initial appointment and periodic review of competency before reappointment. The hospital's duty to guard against physicians' incompetency is further implied by requiring renewal of staff privileges at least every two years (implying a periodic competency review) and the periodic review of the medical records of hospital patients. Although these reviews are conducted by medical staff 'peer' committees, the governing body

of the hospital is responsible for establishing the review procedures. Finally, section 32128 provides that the hospital rules shall include '[s]uch limitations with respect to the practice of medicine and surgery in the hospital as the board of directors may find to be in the best interests of the public health and welfare . . . ' (See Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, *supra*, 8 Pacific L.J. 141, 150-159.)''*

In implementing the statutory requirements of hospital licensure, Title 22 of the California Administrative Code, commencing with Section 707801, sets forth specific requirements as a condition of licensure applicable to the existence and functioning of the medical staff, all relating to the hospital's responsibility for quality of care. Section 70701 provides, in part, that the hospital governing body shall provide for:

“(B) Appointment and reappointment of members of the medical staff.

(D) Formal organization of the medical staff with appropriate officers and bylaws.

(F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis.

*Elam follows a line of state cases commencing with *Darling v. Charleston Community Hospital*, 33 Ill.2d 326, 211 N.E.2d 257, 14 ALR 3d 860 (1965); *Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957); *Johnson v. Misericordia Community Hospital*, 99 Wis.2d 708, 301 N.W.2d 156 (1981).

(7) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter.”

Section 70703 relating to the organized medical staff, in part, provides:

(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital.

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written bylaws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its bylaws. Medical staff bylaws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting rights of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M. or D.D.S. degree or clinical psychology license.

(d) The medical staff shall provide in its bylaws, rules and regulations for the functions to be performed by the following committees: executive, credentials, medical records, tissue, utilization review, infections and pharmacy and therapeutics. In those hos-

pitals where appropriate, these functions may be performed by a committee of the whole or its equivalent. These committees shall make reports of their activities and recommendations to the executive committee and the governing body as frequently as necessary and at least quarterly."

The implementation of the above requirements is monitored pursuant to Section 70101(f):

"(f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection."

If the state finds that there is not ultimate compliance, the hospital license may be cancelled or suspended. This may occur if the medical staff, through the peer review process, fails to take corrective action even though BMQA, the licensing agency for physicians, has not taken action.

CONCLUSION

Medical staff peer review, a process unique to the practice of medicine, is the essential mechanism for assuring quality of patient care. No other system of assuring the development and implementation of quality standards has been devised which better balances competing demands for patient and physician protection. The states, through legislative, judicial and administrative actions, have chosen not only to approve the process but, more

importantly, to mandate the function by integrating it into the seamless web of evolving controls and accountability provided by both physician and hospital licensure. When expanding concepts of tort liability have threatened the process, the states have taken action to protect it, while maintaining the essential rights of those who are subject to peer review decisions.

As a process, peer review, of necessity, involves concerted action in developing and applying practice standards, accepting or denying credentials, and ultimately engaging in corrective action. The basic elements of the system were developed by physicians and hospital governing boards in the legal environment which encourages such action without the overhanging threat of antitrust liability. The system is pro-competitive in encouraging competition based upon quality with full state accountability through reporting and monitoring mechanisms.

Because of the rapid expansion of out-of-hospital services and alternative delivery systems of health care, the mandated use of professional peer review is being expanded and validated. All branches of government have taken responsive action to balance the competing interests expected by the state-mandated peer review process. It is highly questionable whether this function could survive potential liability under the federal antitrust laws, and there is no identified substitute for the process. Even direct government intervention and control could not be designated to achieve a comparable result.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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No. 86-1145

Supreme Court, U.S.
FILED
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1987

TIMOTHY A. PATRICK

Petitioner,

- VS. -

WILLIAM M. BURGET, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF THE
FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC. AS AMICUS CURIAE
IN SUPPORT OF RESPONDENTS**

JANUARY 8, 1988

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QUESTION PRESENTED

The Federation of State Medical Boards of the United States, Inc. will discuss the following question:

Whether the conduct of private physicians and a member of the state Board of Medical Examiners in connection with disciplinary proceedings conducted by the Board is properly admissible as evidence of those physicians' intent in invoking the peer review process at a private hospital or is actionable as part of a conspiracy in restraint of trade involving such peer review proceedings.¹

¹ Briefly, petitioner has presented two questions for review: (1) whether the state action doctrine immunizes respondents' actions in connection with the hospital peer review process; and (2) whether evidence of the conduct of respondents in the proceedings of the Board of Medical Examiners involving petitioner was admissible. The Court invited the Solicitor General to express the views of the United States. The Brief for the United States as Amicus Curiae presents only the first question for review. This Brief Amicus Curiae of the Federation of State Medical Boards of the United States, Inc., presents only the second question for review.

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INTEREST OF AMICUS CURIAE

The Federation of State Medical Boards of the United States, Inc., is a voluntary nonprofit corporation which was established in 1912. Its members include the medical licensing boards of each of the fifty states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

A major portion of the evidence of antitrust violation admitted by the trial court in this case relates to medical disciplinary proceedings before the Oregon Board of Medical Examiners (BOME) in which one of the respondents, Dr. Russell, participated as a member of the Board and other respondents participated as witnesses against the petitioner. It is the position of the Federation that the activities of the respondents in connection with the disciplinary proceedings are exempt from antitrust scrutiny and inadmissible as evidence pursuant to the state action and Noerr-Pennington doctrines.

The interest of the Federation and its members in this case is derived from their concern that, if the Court of Appeals is reversed and the jury's judgment is reinstated, physicians serving as members of state medical and disciplinary boards will be exposed to uninsurable potential antitrust liability involving immense financial risk. Under these circumstances prestigious practicing physicians will be reluctant to accept appointment to state medical boards. Likewise, physicians will abstain from bringing meritorious complaints to state medical boards involving negligent and unethical colleagues. For the most part such complaints emanate from physicians who practice in the same hospital and compete for patients in the same community.

The Federation, its members, and physicians nationwide are concerned about the outcome of this case and its possible effect upon peer review by hospitals and state medical boards. The disciplinary functions of state medical boards would be drastically imperiled if the Court of Appeals is reversed and the jury's judgment reinstated.

SUMMARY OF ARGUMENT

1. State Action Immunity

The activities of a member of a state board of medical examiners and witnesses who appear before the board in medical disciplinary proceedings are immune from antitrust scrutiny under the state action doctrine.

2. Noerr-Pennington Immunity

Communications to influence state agencies are exempt from antitrust scrutiny under the Noerr-Pennington doctrine even if the motivation is solely anti-competitive. The Oregon Board of Medical Examiners is an agency and instrument of the state. The "sham" exception does not apply in the instant case because there was a factual basis for some of the criticism of the petitioner's treatment of patients which the petitioner acknowledged to be justified.

3. Prejudicial Evidence

The admission by the trial court of evidence of the conduct of the respondents in connection with the proceedings before the Oregon Board of Medical Examiners was prejudicial and irrelevant because of the immunity of the respondents from antitrust scrutiny with respect to such conduct.

4. Quality Assurance

If the disciplinary functions of state medical boards are not protected from antitrust scrutiny, negligent, unethical, and malpractice-prone physicians will be able to use the threat of litigation to thwart meaningful investigation and review of their performance to determine whether their license to practice medicine should be revoked or suspended.

ARGUMENT

I. THE PURPOSE OF THE SHERMAN ACT IS TO PROTECT CONSUMERS.

The Sherman Act has been described as a "consumer welfare prescription." *N.C.A.A. v. Board of Regents of University of Oklahoma*, 468 U.S. 85, 107 (1984), citing *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979).

In medicine as in law, self-policing is necessary because lay persons do not have the expertise to evaluate competency in the learned professions. To promote self-policing, the legislature in Oregon as in other states granted immunity from civil liability to persons who in good faith provide information to or testify before state professional boards and committees. Or. Rev. Stat.

677.425(2) (physicians); Or. Rev. Stat. 9.537(1) (lawyers). Physicians and lawyers are granted absolute immunity from civil liability for their actions as members of state professional boards and committees. Or. Rev. Stat. 677.335(1) (physicians); Or. Rev. Stat. 9.537(2) (lawyers).

To overcome the reluctance of physicians to inform on their colleagues, Oregon law as in other states provides that information or testimony given to the state board of medical examiners or to its committees is inadmissible as evidence in any judicial proceeding. Or. Rev. Stat. 677.425(1). The objective of this legislation in protecting informants is to enable state medical boards to take appropriate action to shield the public from negligent and unethical medical doctors.

Medical licensing boards are dependent upon information supplied by physicians who are willing to inform on their colleagues and without such information medical licensing boards would be handicapped in fulfilling their disciplinary functions.

II. IF THE COURT OF APPEALS IS NOT SUSTAINED, COMPETITORS OF A PHYSICIAN INVOLVED IN DISCIPLINARY PROCEEDINGS BEFORE A STATE MEDICAL BOARD WILL BE EFFECTIVELY BARRED FROM PARTICIPATION.

The physicians who provide information against a colleague in state medical board disciplinary proceedings often are competitors. Modern medical practice is divided into numerous specialties and subspecialties and this increases the probability that a physician's performance will be evaluated by his competitors. In literally thousands of hospitals in the United States the performance of medical specialists is peer reviewed by their competitors. In appropriate circumstances, they are ethically or legally obliged to initiate complaints of incompetence in the performance of a colleague that may lead to license revocation, suspension or probation proceedings before a state medical board. If physicians are exposed to potential antitrust liability for providing evidence of a colleague's unprofessional conduct to a state medical board, they will refuse to do so. The profession has been striving to overcome the natural reluctance of physicians to

identify unprofessional conduct on the part of their colleagues. This effort can only be undermined by the threat of antitrust exposure:

There can be no question that the threat of being sued for damages—particularly where the issue turns on subjective intent or motive—will deter “able citizens” from performing essential public service.

Hoover v. Ronwin, 466 U.S. 558, 580 n.34 (1984), citing *Harlow v. Fitzgerald*, 457 U.S. 800, 814 (1982).

The respondents who provided information to the Board of Medical Examiners qualify for immunity. Although the information they supplied in part did not support poor medical practice by Dr. Patrick, charges relating to patient abandonment, failure to diagnose, and unnecessary surgery were admitted by the petitioner to have some validity. As a matter of law, the trial court should have held evidence relating to the disciplinary proceedings before the BOME to be inadmissible and prejudicial under Rules 402 and 403 of the Federal Rules of Evidence. The test of good faith immunity is met if there is evidence that the complaint, testimony, or information given to a medical board for purposes of disciplinary proceedings has a factual basis. A contrary holding would discourage submission of information critical to the disciplinary functions of state medical boards.

To permit a jury to disregard whether there is any factual basis to respondents' charges of unprofessional conduct and to fix antitrust liability by determining that the primary motive of the respondents was to injure the business of a competitor, is inconsistent with the purpose of the Sherman Act, to provide a “consumer welfare prescription.” *N.C.A.A. v. Board of Regents of University of Oklahoma*, 468 U.S. at 107. If a jury is allowed to impute, because of a personality conflict, or personal dislike, or the supposition of motivation to eliminate a competitor, improper antitrust motive on the part of a complainant or witness furnishing valid or partially valid evidence of unprofessional conduct to a state medical board, the disciplinary functions of state medical boards will be materially imperiled, and the public will be thereby exposed to greater risks of incompetent medical care.

III. A MEMBER OF A STATE MEDICAL BOARD ENGAGED IN DISCIPLINARY PROCEEDINGS IS IMMUNE FROM ANTITRUST LIABILITY.

The Oregon Board of Medical Examiners in common with other members of the Federation is an agency and instrumentality of the state. It has the authority to issue, deny, suspend, probate and revoke licenses to practice medicine, to conduct investigations into the competence of physicians, and to conduct contested disciplinary proceedings. It has prosecutorial as well as quasi-judicial functions. The Supreme Court has recognized the need to extend immunity from damage claims to judges, prosecutors, and witnesses in judicial and quasi-judicial proceedings. *Butz v. Economou*, 438 U.S. 478 (1978); *Briscoe v. Lahue*, 460 U.S. 325 (1983); *Imbler v. Pachtman*, 424 U.S. 409 (1976); *Barr v. Matteo*, 360 U.S. 564 (1959).

As a member of the BOME, the activities of respondent Dr. Russell in connection with the disciplinary proceedings brought against Dr. Patrick are quasi-judicial and entitled to immunity from antitrust liability. The Court of Appeals correctly determined that Dr. Russell as a member of the Board of Medical Examiners was "entitled to the same immunity that a judge would receive" and that "all actions complained of fell within the scope of his statutory duties and involved questions well within the jurisdiction of the BOME." *Patrick v. Burget*, 800 F.2d 1498, 1508 (9th Cir. 1986).

IV. RESPONDENTS ARE IMMUNE UNDER THE STATE ACTION AND NOERR-PENNINGTON DOCTRINES WITH RESPECT TO THEIR PARTICIPATION IN THE BOARD OF MEDICAL EXAMINERS PROCEEDINGS.

Dr. Russell as a member of the BOME, and the other respondent witnesses in the BOME disciplinary proceedings against Dr. Patrick, are exempt from liability under the antitrust laws pursuant to the state action exemption. In *Parker v. Brown*, 317 U.S. 341 (1943), the Supreme Court said:

We find nothing in the language of the Sherman Act or its history which suggests that its purpose was to restrain

a state or its officers or agents from activities directed by its legislature. In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.

Id. at 350-51. Since Dr. Russell's activities as a state officer and member of a state board were exempt from antitrust scrutiny, this evidence should have been excluded from the jury by the trial court.

The *Noerr-Pennington* doctrine upholds the right to seek action by government agencies without antitrust liability and despite unethical tactics, provided that the activity is not "a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor." *Eastern Railroad Conference v. Noerr Motor Freight*, 365 U.S. 127, 144 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). In the instant case the evidence received by the BOME that Dr. Patrick engaged in at least some improper medical practices was uncontradicted and the Board, without a vote by Dr. Russell, so found. Accordingly the complaint and the testimony of the respondents as witnesses in the proceedings before the BOME were not baseless and do not come within the "sham" exception to the *Noerr-Pennington* doctrine.

V. EVIDENCE OF THE CONDUCT OF RESPONDENTS IN CONNECTION WITH PROCEEDINGS OF THE OREGON BOARD OF MEDICAL EXAMINERS WAS PREJUDICIAL AND NOT PROPERLY ADMISSIBLE.

In late 1979, respondent Dr. Boelling complained to the hospital medical staff about Dr. Patrick's handling of a case in which he left town while caring for a respirator-dependent patient without arranging for adequate backup support. (Dr. Patrick later admitted that this was a mistake.) The hospital referred this case of abandonment of patient, along with other cases allegedly

handled by Dr. Patrick, to the state Board of Medical Examiners, whose three-member investigative committee was chaired by Dr. Russell. Drs. Boelling and Harris testified before the committee. The Board issued a letter of reprimand which was retracted when Dr. Patrick sought judicial review in state court.

The petitioner acknowledges that he suffered no damages from the letter of reprimand issued and later revoked by the Board of Medical Examiners (apart from legal fees in connection with the BOME proceedings) and "that his income continued to climb after the letter." (Pet. Brief 41). He argues, however, that evidence of what happened at the Board "was admissible, whether or not the conduct itself was protected by the state action doctrine." (Pet. Brief 31). As noted by the petitioner, the Court of Appeals "reversed because of the admission of evidence of actions which were exempt under the state action doctrine." (Pet. Brief 42).

Evidence of the conduct of the respondents in connection with the proceedings of the BOME was prejudicial and not properly admissible in an action charging a conspiracy in restraint of trade involving a peer review proceeding and the referral of patients. As stated in *U.S. Football League v. National Football League*, 634 F. Supp. 1155, 1181 (S.D.N.Y. 1986):

[T]he exclusion of "purpose and character" evidence consisting of conduct embraced by *Noerr-Pennington* should be the rule rather than the exception in an antitrust case. Although Rule 403 requires that evidence should be excluded only if its probative value is "substantially outweighed" by its prejudicial effect, evidence which by its very nature chills the exercise of First Amendment rights . . . is properly viewed as presumptively prejudicial.

Also, the lengthy presentation of such evidence of respondents' conduct at trial may have unnecessarily confused the issues in the instant case and may have misled the jury. It should not have been admitted.

VI. IMPROVING THE QUALITY OF PATIENT CARE AND CURBING THE OCCURENCE OF MALPRACTICE CLAIMS DEPENDS UPON PROTECTING THE PEER PROCESS AGAINST EROSION.

The occurrence of medical malpractice claims has become a matter of grave national concern. A substantial percentage of those incidents giving rise to meritorious malpractice claims might have been avoided if incompetent or impaired physicians had been appropriately limited in their hospital privileges or denied access to hospital facilities.

Meaningful peer review in hospitals and disciplinary action by state medical boards is essential to protect the public from incompetent and negligent health care practitioners. The Federation encourages physicians to participate actively in peer review in order to protect the public from substandard medical services. The various states, likewise, have enacted legislation designed to provide a substantial degree of legal immunity to those who participate in peer review of their colleagues. A judicial determination that this legislation is of no consequence in antitrust litigation would be detrimental to the public interest.

CONCLUSION

For the reasons stated above, the Federation of State Medical Boards of the United States, Inc., urges the Court to affirm the decision of the Court of Appeals in reversing the judgment rendered in the trial court.

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BRIEF

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IN THE
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OCTOBER TERM, 1987

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WILLIAM M. BURGET, *et al.*,
Respondents

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OREGON ASSOCIATION OF HOSPITALS, AND
AMERICAN MEDICAL PEER REVIEW ASSOCIATION
AS AMICI CURIAE IN SUPPORT OF RESPONDENTS**

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QUESTION PRESENTED

Amici Curiae will address the following question:

Whether the court of appeals correctly held that physician participation in Oregon's mandatory peer review program constitutes "state action" immune from lawsuits brought under the Sherman Act, 15 U.S.C. §§ 1, *et seq.*, when the state regularly monitors the program for compliance with state law, guarantees that peer review will be conducted with procedural safeguards and provides for state review of any peer review decision at the request of an injured physician.

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IN THE
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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION,
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 AMERICAN MEDICAL PEER REVIEW ASSOCIATION
 AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

—
INTEREST OF THE AMICI CURIAE

Amici curiae represent major national and state organizations concerned with medical and hospital care. Each *amicus* is dedicated to maintaining high professional health care standards and quality hospital and medical care through effective professional peer review. The organizations herein represented are:

(1) The American Medical Association ("AMA") was established in 1847 to promote the science and art of medicine. The AMA has over 280,000 members. The AMA

and its members participate in a wide range of accreditation, certification and peer review programs designed to enhance the quality of medical care for patients. Accordingly, the AMA and its members have a significant interest in any case that may affect how the federal anti-trust laws are applied to the medical profession's efforts to enhance the quality of medical practice.

(2) The American Hospital Association ("AHA") was founded in 1898 and is the primary organization of hospitals in the United States. It is a non-profit membership corporation whose principal corporate objective is to promote high quality health care and health services for all people through leadership and assistance to hospitals and health care organizations in meeting the health care needs of their communities. AHA's membership includes approximately 6,000 hospitals and other health care institutions, as well as approximately 45,000 individuals. AHA and its members are committed to effective hospital-based peer review.

(3) The Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") is comprised of the following member organizations: American Hospital Association, American Medical Association, American College of Surgeons, American College of Physicians and American Dental Association. The Joint Commission is the primary private hospital accreditation body in the United States. It accredits more than 5,000 hospitals nationwide on the basis of voluntary compliance with its standards. For the purpose of providing hospital services eligible for reimbursement under the federal Medicare program, 42 U.S.C. § 1395x(e) defines an eligible hospital to include, *inter alia*, an institution that "is accredited by the Joint Commission on Accreditation of Hospitals."¹

¹ Recently, the Joint Commission on Accreditation of Hospitals changed its name to the Joint Commission on Accreditation of Healthcare Organizations.

Joint Commission standards require each accredited hospital to employ an internal system of professional peer review. The Conditions of Participation of the federal Medicare program contain similar requirements. 42 C.F.R. § 482.22. The Health Division in the State of Oregon, pursuant to Or. Rev. Stat. § 441.055, may accept accreditation by the Joint Commission as evidence of compliance with Oregon state hospital standards. The Joint Commission is committed to medical peer review activity as necessary to its mission of promoting quality health care in hospitals.

(4) The Oregon Medical Association ("OMA") is a constituent state medical association within the federation of the AMA. It has more than 4,000 physician members including the petitioner and the respondent physicians in this case. In common with the AMA, the OMA is dedicated to advancing the science and art of medicine and the improvement of public health.

(5) The Oregon Association of Hospitals ("OAH") is an allied state association of the AHA and shares the AHA's commitment to furthering high quality health care and services. The OAH is a voluntary association whose members are 78 Oregon hospitals, which includes every private and public general hospital in the state.

(6) The American Medical Peer Review Association ("AMPRA") is a non-profit membership organization of parties interested in the field of medical quality assurance and utilization review. Forty-one of its members are Peer Review Organizations (PROs)—organizations designated by the federal government to conduct review of care delivered under the Medicare program. AMPRA and its members are committed to developing and implementing effective methods of assessing the quality of medical care.

Amici's interest in this case arises from their shared commitment to high quality medical and hospital care. They believe that this commitment can best be met when

physicians conduct effective peer review according to their clinical judgment and professional standards, uninhibited by the threat of retaliatory litigation and the fear of uninsurable risks.

The judgment of the district court, imposing liability and awarding treble damages under the Sherman Act against individual physicians engaged in peer review, discouraged many physicians from participating in peer review. See Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987). The holding of the court of appeals conferring immunity upon the respondents allayed many fears and thereby promoted rigorous peer review. *Id.* at 598. *Amici* thus wish to present their views in support of the holding of the court of appeals, and, in any case, to urge the Court to provide clear guidance regarding the steps a state must take in order to immunize peer review from federal antitrust liability.²

STATEMENT

Background

During the past decade, as the medical malpractice problem in this country has worsened and as the nation's demand for medical services has grown, there has been an increasing emphasis on measures that will improve the quality of medical care. Foremost among these measures is effective peer review of the medical practices of physicians, particularly those who practice in hospitals. Indeed, effective peer review is essential to ensuring quality medical care in the United States. *Marrese v. Interqual, Inc.*, 748 F.2d 373, 392 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985). Consequently, after intensively studying the medical malpractice problem and finding a need for legislation to address the quality of

² Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

medical care,³ Congress passed the Health Care Quality Improvement Act of 1986 to promote effective peer review. 42 U.S.C. §§ 11101, *et seq.*

The Act was predicated upon two specific findings which are directly relevant to this case. Congress recognized that "[t]he threat of private money damage liability . . . under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review" and that "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. §§ 11101(4) and (5).⁴

This commitment to peer review by Congress reflects its realization that peer review is necessary to maintain high standards of medical care in hospitals. See H.R. Rep. No. 903, 99th Cong., 2d Sess. 2-3, *reprinted in* 1986 U.S. Code Cong. & Admin. News 6384, 6384-85. As in any other technical and highly specialized field, the identification of substandard practitioners requires the active participation of their competent and qualified colleagues. Review of medical practices can be done most effectively and meaningfully by peers. *Cf. Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1491 (D.C. Cir. 1984).

Peer review also serves the essential function of ensuring that physicians practice only within their areas of competence. Through the licensing process, states eval-

³ Medical Malpractice: Hearings on H.R. 5110 Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 99th Cong., 2d Sess. 2 (1986) (Opening statement of Rep. Henry A. Waxman, Chairman).

⁴ Although Congress did not confer absolute immunity upon peer reviewers who comply with the procedural standards set out in 42 U.S.C. § 11112(a), it did expressly preserve all existing "immunities under law," including the state action immunity, 42 U.S.C. § 11115(a). *See, infra*, p. 24.

uate physicians on the basis of a general standard of fitness to practice medicine. All physicians receive the same license and therefore the same entitlement to perform medical procedures. See, *e.g.*, Or. Rev. Stat. §§ 677.085 and 677.110(3).⁵ The state leaves it to the medical profession and hospitals to ensure that each physician performs only those procedures for which the physician is qualified by his or her specific training and experience. See, *e.g.*, Or. Rev. Stat. § 441.055(3)(b). Indeed, Oregon requires its hospitals to adopt and implement a peer review process. See, *infra*, pp. 13-14. Through peer review, decisions are made whether to admit a physician to a hospital's medical staff and later whether to keep the physician on the staff. The peer review process also determines the extent of a physician's privileges, for example, whether a surgeon may perform appendectomies, heart valve replacements or kidney transplants.

The initial recommendation concerning this array of privilege decisions is made by physicians on the medical staff, because they are the individuals most capable of making the complicated and sensitive medical judgments involved. Generally, the board of trustees makes the final determination whether to deny, restrict or revoke privileges. See *Accreditation Manual for Hospitals/1988* ¶ M.S.4.2.7, at 120 (Joint Commission on Accreditation of Healthcare Organizations 1987).⁶ Naturally, great deference is paid to the judgment of the professional peers, but the board of trustees, acting independently, makes the final decision.

Peer review recommendations denying, restricting or revoking privileges can provoke anger and can have a

⁵ States also have provisions for temporary, limited licenses in certain cases until the physician qualifies for an unlimited license. See, *e.g.*, Or. Rev. Stat. § 677.132.

⁶See also Bylaws, Rules and Regulations of the Medical Staff, Columbia Memorial Hospital, art. VIII, § 7 and definition 2. PX 156.

significant adverse economic impact on the affected physician. Consequently, physicians who are denied staff privileges or who have their privileges restricted or revoked often vigorously challenge that action through litigation. As one court noted in the early 1980's, "[a]ntitrust suits grounded on the denial, termination, or limitation of hospital staff privileges have proliferated in recent years." *Pontius v. Children's Hospital*, 552 F. Supp. 1352, 1362 (W.D. Pa. 1982). This threat of retaliatory litigation has become a substantial impediment to effective peer review. See Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597, 597 (1987).

Statement of the Case

1. Astoria, Oregon is a city of 10,000 people and one hospital, Columbia Memorial Hospital. A majority of the medical staff members at Columbia Memorial are also employees or partners of the Astoria Clinic. Pet. App. 2a.

Petitioner, Dr. Timothy A. Patrick, joined the medical staffs of the Astoria Clinic and Columbia Memorial in 1972. After one year, he received and declined an offer of partnership in the clinic. Instead, he opened an independent practice in competition with the surgeons at the clinic. Pet. App. 2a-3a. He continued as a staff member of Columbia Memorial. Respondents are the Astoria Clinic and eleven physicians who were on the staff of the clinic during the period relevant to this case.

In 1979, a partner at the clinic, respondent Dr. Gary Boelling, triggered an investigation of petitioner's medical practices by the Oregon Board of Medical Examiners on the basis that petitioner had negligently managed the post-operative care of one of his patients. A three-member investigative committee, chaired by respondent Dr. Franklin Russell, also a partner at the clinic, criticized petitioner's practices, and the Board issued a letter of reprimand. The Chairman of the Board of Medical Ex-

aminers, Dr. Tanaka, who was not associated with the Astoria Clinic, believed that the letter overstated petitioner's inadequacies. When petitioner sought judicial review, the Board retracted its reprimand. Pet. App. 5a-6a.

In 1981, after another significant incident of apparently negligent care by petitioner and at the urging of respondent Dr. Richard Harris, a clinic surgeon, the Columbia Memorial peer review committee initiated a review of petitioner's privileges. Pet. Br. 24-25. Respondent Boelling chaired the committee which recommended termination of petitioner's privileges. Pet. App. 7a. Pursuant to hospital bylaws, the peer review committee granted petitioner's request for a hearing. Pet. Br. 25. Before the committee reached a final recommendation, which would be sent to the hospital's board of trustees, however, petitioner resigned from the hospital staff. Pet. App. 8a.

2. Before the peer review of his staff privileges was concluded, petitioner filed this lawsuit in the United States District Court for the District of Oregon. He alleged violations of federal antitrust law and state tort law. Specifically, he alleged that respondents pursued peer review in order to stifle his competition for patients. A jury returned a verdict for petitioner on all counts. Pet. App. 8a.

The court of appeals reversed. Pet. App. 8a-17a. With respect to the "state action" doctrine, the court held that Oregon's mandatory system of peer review immunized the peer review activities of the respondents against suits under federal antitrust law.⁷

⁷ With respect to the state law claims, the court vacated the judgment on the ground that the jury had been improperly instructed. Pet. App. 14a-17a. That holding is not before this Court.

SUMMARY OF ARGUMENT

A.

Under the state action doctrine, when private individuals act pursuant to state legislative policy and with clear state authorization, they may not be sued under the federal antitrust laws, no matter how anticompetitive their conduct might be. *Hoover v. Ronwin*, 466 U.S. 558, 567-69 (1984). This is because the Sherman Act was not intended to interfere with the states' ability to effectuate policies that they deem necessary to serve the public interest—even when those policies are carried out by private individuals. This Court has made clear that there is adequate state authorization to immunize the conduct of private individuals when that conduct is undertaken pursuant to a clearly articulated state policy to replace competition with regulation and when the state actively supervises the conduct. *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

B.

A state clearly articulates a policy permitting private conduct free from antitrust review when it expressly permits or compels private parties, *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 61-62 (1985), to engage in activities that are facially anticompetitive or that have foreseeable anticompetitive effects, *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 41-43 (1985). Oregon expressly mandates peer review in specific terms even though it recognizes that peer review may have certain anticompetitive effects. Consequently, Oregon satisfies the "clear articulation" prong of the state action doctrine.

The extent to which a state must "actively supervise" private conduct in order to immunize it from the antitrust laws is based upon a pragmatic analysis of the purposes

of the state action doctrine and the active supervision requirement. *Town of Hallie*, 471 U.S. at 46-47. In particular, by allowing states to implement their policies through private action, the state action doctrine permits states to employ the full range of regulatory alternatives necessary to achieve their goals. *Southern Motor Carriers*, 471 U.S. at 62. Comprehensive review of every peer review decision in every hospital by an agent of the state is wholly impracticable and therefore inconsistent with this purpose.

The active supervision requirement serves three purposes. It establishes that the state is committed to regulation. *Southern Motor Carriers*, 471 U.S. at 61 n.23. It provides some assurance that the private conduct at issue advances the state's purposes. *Town of Hallie*, 471 U.S. at 46. And, it affords a remedy to an adversely affected physician as a substitute for the federal antitrust laws. These purposes are satisfied when, as in Oregon, active supervision of peer review activities includes (1) general and periodic review of the peer review system by the state, (2) strict procedural safeguards embodied in the peer review process and (3) available judicial or administrative recourse for adversely affected physicians. *Marrere v. Interqual, Inc.*, 748 F.2d 373, 390-95 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

Because Oregon's peer review process satisfies the purposes of the active supervision requirement as well as the fundamental purposes of the state action doctrine, respondents' conduct is immune from petitioner's lawsuit under the federal antitrust laws.

C.

The state action doctrine must not be applied in a way that unnecessarily frustrates the interests of both state sovereignty and unfettered competition. *Southern Motor Carriers*, 471 U.S. at 61. A denial of state action immunity in this case, however, would impair Oregon's interest in effective peer review because, as Congress has

found, peer review is severely threatened if physicians are subject to protracted litigation under the federal antitrust laws. Moreover, a denial of immunity would impair competition in the delivery of health care in Oregon because peer review plays an important role in fostering competition.

ARGUMENT

UNDER THE STATE ACTION DOCTRINE, OREGON PHYSICIANS ENJOY IMMUNITY AGAINST FEDERAL ANTITRUST SUITS FOR THEIR PEER REVIEW ACTIVITIES.

A. In Deciding Whether Private Conduct Is Immune From The Federal Antitrust Laws Under The State Action Doctrine, This Court Has Required A Showing That The Conduct Represents Clearly Articulated State Policy And That The State Actively Supervises The Conduct.

The state action doctrine, which holds that federal antitrust prohibitions are not applicable to the states, is "grounded in concepts of federalism and state sovereignty." *Hoover v. Ronwin*, 466 U.S. 558, 573 n.24 (1984). See *Parker v. Brown*, 317 U.S. 341 (1943). In *Parker*, this Court considered the antitrust implications of a California statute regulating the marketing of raisins. The Court found no intent by Congress in either the language or the legislative history of the Sherman Act to limit the conduct of the states. *Parker*, 317 U.S. at 350-51. In particular, this Court concluded that Congress "did not intend to compromise the States' ability to regulate their domestic commerce." *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 56 (1985). Consequently, under the principle of federalism that states are sovereign except where Congress "constitutionally subtract[s] from their authority," the

Court established the fundamental rule that actions of a state are "*ipso facto* . . . exempt from the operation of the antitrust laws," *Hoover*, 466 U.S. at 567-68, no matter how anticompetitive those actions are.

But the states do not and cannot depend exclusively upon state officials and employees to serve all of their public purposes. By relying upon the actions of private parties, states are able to employ the full range of regulatory alternatives necessary to ensure that their policies are fulfilled. *Southern Motor Carriers*, 471 U.S. at 62. An antitrust suit against private parties acting pursuant to clearly articulated state policy, however, can prevent implementation of state policy just as effectively as a suit brought directly against the state. *Southern Motor Carriers*, 471 U.S. at 56-57. Accordingly, this Court has also recognized that state action immunity must protect private parties acting under a state plan to regulate commerce, even though the private conduct may have anticompetitive effects.

For private parties to engage in "state action" for purposes of immunity, the anticompetitive conduct must in fact be authorized by the state. In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980), this Court described a general, two-part test for deciding when state legislatures have conferred antitrust immunity on the actions of private parties:

First, the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy"; second, the policy must be "actively supervised" by the State itself.

(quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (plurality opinion)). See 324 *Liquor Corp. v. Duffy*, 107 S. Ct. 720, 725 (1987); *Southern Motor Carriers*, 471 U.S. at 57; *Hoover*, 466 U.S. at 569.

B. Oregon Has Clearly Articulated A Policy Of Substituting Mandatory Peer Review For Unrestricted Competition Among Physicians, And Oregon Actively Supervises The Peer Review Conducted By Its Physicians.

1. Oregon Satisfies The Clear Articulation Requirement.

A state clearly immunizes conduct as state policy when it expressly permits or compels private parties, *Southern Motor Carriers*, 471 U.S. at 61-62, to engage in activities that are facially anticompetitive or that have foreseeable anticompetitive effects, *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 41-43 (1985). In adopting its system of peer review, Oregon satisfied the clear articulation requirement. Oregon compels its physicians to perform peer review. Moreover, it does not simply compel peer review as a general proposition but mandates peer review in specific terms. Finally, while peer review is largely procompetitive, some anticompetitive effects are an inevitable, and readily foreseeable, result of the peer review mandated by the state. Compare *Town of Hallie*, 471 U.S. at 41-43; *Silver v. New York Stock Exchange*, 373 U.S. 341, 349, 360 (1963).

Under Oregon law, hospitals may operate only if they are licensed. Or. Rev. Stat. § 441.015(1). Oregon further requires, as a condition of licensure, that its hospitals adopt and implement effective procedures for peer review. Or. Rev. Stat. §§ 441.025(1), 441.030(2) and 441.055(3). In particular, Oregon's peer review provisions require peer reviewers to ensure that (a) physicians are currently licensed or registered, (b) physicians are granted hospital privileges consistent with their individual training, experience and other qualifications, (c) procedures for granting, restricting and terminating privileges exist, are regularly reviewed and conform to applicable law and (d) physicians review professional practices for the purpose of reducing morbidity and mor-

tality and for the improvement of patient care. Or. Rev. Stat. § 441.055(3).⁸ Hence, physicians in Oregon must perform peer review and they must perform it in accordance with the state's specific guidelines.

In mandating peer review, the Oregon legislature effectively mandated some anticompetitive effects in the market for health care services. By virtue of his or her state medical license, an Oregon physician is entitled to perform any medical procedure anywhere in the state. Or. Rev. Stat. §§ 677.085 and 677.110(3). Under Oregon's system of peer review, like most other states', however, a physician's colleagues recommend both whether and to what extent the physician can practice medicine at a particular facility. Or. Rev. Stat. § 441.055(3). Peer review decisions excluding a physician from a hospital staff or limiting the kinds of procedures a physician may perform, therefore, necessarily decrease the number of physicians available to a patient who needs a particular treatment. Thus, like other limitations on consumer choice, restrictions imposed on the market by peer review are certainly "anticompetitive" in one sense. *Coastal Neuro-Psychiatric Associates, P.A. v. Onslow Memorial Hospital, Inc.*, 795 F.2d 340, 342 (4th Cir. 1986); *Marrese v. Interqual, Inc.*, 748 F.2d 373, 387-89 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985).

Oregon decided, however, that these limitations on consumer choice were greatly outweighed by the overall beneficial impact of private peer review, including its procompetitive effects. See, *infra*, pp. 23-26. Accordingly, Oregon expressly chose to employ peer review to ensure quality health care and replace competition with private and state regulation as a matter of state policy.

⁸ Moreover, Oregon indicates to private physicians how they should conduct their peer review activities by conducting its own peer review process through the agency of the Board of Medical Examiners. Oregon has enumerated twenty-five grounds which might justify suspending, revoking or refusing to grant a license to practice medicine in the state. Or. Rev. Stat. § 677.190.

Thus, Oregon's system of peer review satisfies the first prong of the *Midcal* test for state immunity for private conduct.⁹

2. Under The Pragmatic Approach Employed By This Court, Oregon Adequately Supervises Peer Review Activities To Confer Antitrust Immunity.

a. In analyzing whether particular conduct undertaken by actors who are not directly employed by the state can be deemed state action for Sherman Act purposes, the Court has generally required that the state "actively supervise" the conduct. *324 Liquor Corp.*, 107 S. Ct. at 725; *Southern Motor Carriers*, 471 U.S. at 57; *Hoover*, 466 U.S. at 569; *Midcal*, 447 U.S. at 105. But the "active supervision" requirement is not a static concept. The amount of supervision required by the state must depend upon the circumstances of each case in light of both the overall purposes of state action immunity and the purposes of the supervision requirement.¹⁰ Thus, in *Town of Hallie*, this Court held that a municipality was completely exempt from any requirement of state supervision. 471 U.S. at 46-47.

Town of Hallie indicates that the Court takes a pragmatic view of the active supervision requirement. Not all conduct by all non-state actors must or should be subject to the same degree of review in order to qualify as state action. Analyzing peer review from a practical perspective, it is plainly inappropriate to require as a condition of immunity that each and every peer review decision be directly and comprehensively reviewed by an agent of the state.

In the first place, such a requirement would undermine the purposes of the state action doctrine by making state compliance impossible. No state can meaningfully re-

⁹ The Government implicitly concedes this point. U.S. Br. 7.

¹⁰ Cf., *Mathews v. Eldridge*, 424 U.S. 319, 334-35 (1976) (observing that due process is a flexible concept whose requirements vary with the particular context involved).

view every peer review decision. At most hospitals at which privileges are sought, each physician must file an initial application for privileges and, every two years thereafter, a renewal application. See, e.g., *Accreditation Manual*, *supra*, ¶ MS.4.2.9. For the roughly half million physicians in the United States, this process alone involves hundreds of thousands of decisions annually. Moreover, for every application, it must be decided which procedures the physician is permitted to perform.¹¹ Hence, there are literally millions of peer review decisions every year. Even if the states wished to review all the decisions, they could not.

Thus, to require comprehensive review as an element of active supervision in this context would impair the states' ability to improve the quality of health care through peer review and thereby undermine one of the core purposes of the state action doctrine, *viz.*, to permit the states to promote their important interests through the agency of private actors when necessary. *Southern Motor Carriers*, 471 U.S. at 56-57; 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 212b, at 69-70 (1978). See, *supra*, pp. 11-12.

Second, comprehensive oversight of peer review decisions is unnecessary because of the clarity with which Oregon has articulated peer review as state policy. Commentators, see 1 P. Areeda and D. Turner, *supra*, ¶ 212c, at 71, and this Court, see *Town of Hallie*, 471 U.S. at 46-47, have emphasized the interrelationship between the clear articulation and active supervision requirements. If a state compels behavior in specific terms, that behavior is more likely to serve the state's purposes than if the state merely permits certain conduct in general

¹¹ The application for general surgery privileges at Fairfax Hospital in Fairfax, Virginia, for example, lists 75 operations and procedures. See Appendix A, pp. 1a-4a, *infra*.

terms.¹² Where, as here, one of the two state action requirements is more clearly satisfied, a lesser showing on the other requirement is appropriate to demonstrate state authorization.

Comprehensive review is also unnecessary because, unlike ordinary businesses, professionals generally engage in concerted action in order to achieve purposes that are typically procompetitive. *National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 (1978). Relaxing the supervision requirement for physicians whose usual motivation is fully consistent with the state's purpose is thus a reasonable application of this Court's observation that "[t]he public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975). See *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 348-49 (1982). Accordingly, while it may be necessary for the state to review every joint rate filed by common carriers in order for the state to confer immunity upon their price-setting activities, it should not be necessary to review every decision made by physicians scrutinizing their peers' medical practices for competence.

b. The extent to which the state must supervise should be guided by the policies underlying the requirement of state supervision and constrained by what is practicable. This Court has expressly recognized that active supervision by the state serves two purposes: First, it demonstrates that the state has in fact chosen to substitute regulation for competition in a particular area. *Southern*

¹² Similarly, if a state actively reviews and approves anticompetitive conduct, the courts can more readily conclude that the conduct represents state policy. See 1 P. Areeda and D. Turner, *supra*, ¶ 212c, at 71.

Motor Carriers, 471 U.S. at 61 n.23; *Town of Hallie*, 471 U.S. at 39. Second, it decreases the risk that the federal interest in competition will be sacrificed by conduct that does not advance the state's purposes. *Town of Hallie*, 471 U.S. at 46. In addition, the requirement serves a third purpose—it increases the likelihood that a competitor who is injured will have some remedy available, in lieu of a treble damages action, in the event that non-state actors in fact are promoting their own interests at the expense of the state's. U.S. Br. 9 (observing that active supervision occurs when a state official acts "to correct any abuses" by private actors). Cf. *Silver*, 373 U.S. at 363.

In order to promote these purposes without unduly confining the state's discretion in how it may operate a peer review system, the Court should employ the three-part analysis for active supervision of medical peer review practices that was suggested by the Seventh Circuit's opinion in *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985). In *Marrese*, the court held that immunity was appropriate because the state (1) regularly reviewed each hospital's peer review process on a general basis, (2) expressly assured physicians that they would receive procedural safeguards prior to any discipline in the peer review process and (3) provided judicial review of any sanctions that were imposed. 748 F.2d at 390-95.

The requirements identified in *Marrese* fully advance the purposes of supervision by the state. First, by reviewing regularly each hospital's peer review process on a general basis, a state can identify and correct those peer review practices that are conducted inappropriately before they significantly undermine the state's interests. Moreover, general oversight, particularly in the context of private peer review mandated by the state, fully demonstrates the state's commitment to peer review regulation as a substitute for competition. *Southern Motor Carriers*, 471 U.S. at 61 n.23.

Second, by requiring procedural safeguards before hospitals can discipline physicians, a state further limits the likelihood of effects not desired by the state. In addition, fair procedures increase the likelihood that a potentially injured physician will have some protection from abuses by peers apart from the antitrust laws. Cf. *Silver*, 373 U.S. at 361-63.

Finally, by providing administrative or judicial remedies to physicians who are unfairly injured by peer review, a state can provide reasonable assurance that it will quickly identify and remedy any improper peer review decisions that are made. Because the state is unable, as a practical matter, to detect the few victims of improper peer review, oversight will be most effective if the victims identify themselves and the state then provides a remedy for any abuses. In sum, a combination of automatic and general supervision, procedural safeguards and a mechanism for intensive review that can be activated by an injured person advances the essential purposes of the active supervision requirement for state action immunity.

c. Oregon has adopted procedures that satisfy the active supervision requirement. Under Oregon law, hospitals must regularly review the peer review actions of its physicians to assure their conformity to applicable law, Or. Rev. Stat. § 441.055(3)(c), and must annually report on their peer review proceedings. Or. Admin. R. 333-70-015(2). Oregon, in turn, will not license a hospital unless it finds that the hospital is complying with its obligation to conduct peer review properly. Or. Rev. Stat. § 441.025(1). Once a hospital is licensed, Oregon monitors hospitals on an annual basis to insure that they are still complying with their obligations under Oregon law. Or. Admin. R. 333-70-045(2). In the range of oversight procedures that are feasible, Oregon's procedures are rigorous. Moreover, the already strict satisfaction of

the clear articulation prong diminishes the need for comprehensive review of all cases to satisfy the active supervision prong.

Oregon also requires its hospitals to follow fair procedures in making peer review decisions. According to Oregon Revised Statutes § 441.055(3)(c), hospitals must "[i]nsure that procedures for granting, restricting and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law."¹³ *Straube v. Emanuel Lutheran Charity Board*, 287 Or. 375, 600 P.2d 381, 384 n.4 (1979), cert. denied, 445 U.S. 966 (1980).

Columbia Memorial Hospital provides ample procedural safeguards. According to its peer review provisions, Columbia Memorial requires that, if the executive committee, as in this case, recommends termination of privileges, the physician is entitled to a due process hearing before a hearing committee. See Bylaws, Rules and Regulations of the Medical Staff, Columbia Memorial Hospital, art. VIII, §§ 1-5 (PX 156). The hearing committee reports to the executive committee whether the executive committee should confirm, modify or reject its earlier recommendation to terminate. See *id.* at art. VIII, § 5(k). After reviewing the hearing committee's report, the executive committee makes a final recommendation to the hospital's board of trustees. See *id.* at art. VIII, § 5(k) and art. V, § 2. As of right, the physician may then appeal an adverse recommendation to the board before the board renders the final decision. See *id.* at art. VIII, §§ 1, 6 and 7 and definition 2.

Finally, Oregon provides administrative and judicial mechanisms for very close supervision that can be readily activated when anticompetitive conduct does occur. When peer review is improperly conducted, the victimized phy-

¹³ Implicit in a duty to provide procedures is a duty to provide fair procedures.

sician may complain to the Health Division. The Division must then intensively investigate the peer review decision.¹⁴ The physician may also turn to the Oregon courts for vindication. As mentioned, Oregon has imposed upon its health care facilities a statutory duty to provide fair procedures. *Straube*, 600 P.2d at 384 n.4 (citing Or. Rev. Stat. § 441.055(3)(c)). Judicial review of the duty to provide fair procedures would ensure "that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that [the physician's] conduct posed a threat to patient care." *Straube*, 600 P.2d at 386.¹⁵

Moreover, by focusing on a duty of fair procedures, Oregon provides the appropriate degree of judicial review. Substantive review of decisions turning on professional competence is problematic for the courts especially if the issues must be decided by a jury. *Marrese*, 748 F.2d at 393.¹⁶

¹⁴ Or. Admin. R. 333-70-045(1)(a) provides that:

The [Health] Division shall ensure that all complaints received by the Division regarding violations of Health Care Facilities laws are investigated. The investigations will be carried out as soon as practicable and will include but not be limited to, as applicable to facts alleged: interviews of the complainant, patient(s), witnesses, and HCF management and staff; observations of the patient(s), staff performance, patient environment and physical environment; and review of documents and records.

¹⁵ See also Resp. Supp. Br. in Opp. 7-9.

The Government's concern that Oregon has not clearly provided a common law right of fair procedures in peer review decisions, U.S. Br. 13-14, is misplaced because Oregon has imposed a statutory duty of fair procedures. *Straube*, 600 P.2d at 384 n.4 (citing Or. Rev. Stat. § 441.055(3)(c)).

¹⁶ Of course, there is no way to know whether the state supervision available in this case would have protected petitioner because he aborted the peer review process. The appeal before the board of trustees that petitioner was entitled to would have given

The United States argues that the degree of supervision by Oregon does not rise to the level of active supervision found in *Southern Motor Carriers*, 471 U.S. at 62-63, *Bates v. State Bar*, 433 U.S. 350, 362 (1977), or *Parker*, 317 U.S. at 352. But the United States makes no attempt to analyze Oregon's scheme in light of the purposes of the active supervision requirement. Moreover, the government completely ignores the nature of peer review and the impracticality of a direct review of each decision by the state. Finally, the government undervalues the utility of Oregon's supervision by asking whether each component of oversight would alone suffice if very close supervision were required instead of asking whether the different components in combination add up to the amount of supervision that is appropriate to convert private peer review into state action. Properly analyzed, Oregon's system of peer review provides adequate supervision of the private peer review conduct of respondents, and accordingly their conduct undertaken pursuant to the state's authorization was immune from petitioner's federal antitrust suit.¹⁷

him review by individuals not in competition with him. There is no reason to assume, given the nature of petitioner's criticisms outlined in detail in his brief, Pet. Br. 1-35, that the board would not have assessed his practices fairly. In fact, the record indicates that, when petitioner was reviewed by individuals without an economic interest in his practices, such as Dr. Tanaka of the Board of Medical Examiners, he was reviewed fairly. Pet. Br. 21. See Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1125 (recommending less judicial scrutiny of peer review decisions when the hospital makes a judgment independent of the medical staff).

¹⁷ In the past year, Oregon has adopted an additional mechanism for supervision of the peer review process. Upon the request of the physician being reviewed, the reviewing hospital's medical staff and the reviewing hospital's governing board, the Oregon Board of Medical Examiners may appoint one or more physicians to conduct the peer review. Or. Rev. Stat. § 441.055(6). The physicians appointed by the Board are then considered agents of the

C. Denying State Action Immunity For Oregon's Peer Review System Will Frustrate The Purposes Of Both Federal And State Law.

In *Southern Motor Carriers*, this Court emphasized that the state action doctrine should not be applied in a manner that would unnecessarily impair both of the underlying interests of state sovereignty and unfettered competition, which are implicated in any case involving state action immunity from the Sherman Act. Hence, the Court rejected a per se requirement of compulsion for the clear articulation prong on the basis that such a requirement would limit the ability of the states to implement their policies while *increasing* the potential for anticompetitive conduct. 471 U.S. at 61. A requirement that Oregon must do more to authorize peer review or a holding that effectively prevents Oregon from authorizing peer review to serve as state action would frustrate the interest of Oregon in effective peer review and stifle competition in Oregon's health care industry.

As previously discussed, Congress has expressly recognized that peer review is severely threatened unless immunity protects the reviewing physician against harassing antitrust lawsuits. Congress' specific findings bear repeating: "The threat of private money damage liability . . . under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review" and "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. §§ 11101(4) and (5). With their treble damage

state of Oregon in their role as peer reviewers. Or. Rev. Stat. § 441.055(7).

In view of this modification of Oregon law, this case will have limited prospective significance. Consequently, the Court might wish to consider whether the writ in this case should be dismissed as improvidently granted.

awards, attorneys' fee provisions and complex legal and factual issues, peer review suits alleging antitrust violations are particularly burdensome to physicians.

Although the Health Care Quality Improvement Act now grants qualified immunity against liability for damages, peer reviewers still must pay the attorneys' fees and expenses necessary to establish the qualified immunity defense.¹⁸ Moreover, the Act's immunity is no consolation for those physicians, like respondents, who have already performed peer review on behalf of the state. It would be manifestly unfair to deny immunity on the basis of Congress' nationwide decision to ensure that all physicians receive some protection. Finally, by expressly not changing existing immunities, 42 U.S.C. § 11115(a), the Act clearly intends to grant good faith immunity as a minimum, leaving states free to provide full antitrust immunity under *Parker* if they so desire. Consequently, a requirement of the state action doctrine that could not be met in practice would undermine Congressional intent.

A denial of immunity will also frustrate the Sherman Act's goal of unfettered competition. In the vast majority of cases, the peer review process will be procompetitive. Peer review identifies substandard practitioners, who might otherwise go undetected by patients because of their inability to assess physician competence meaningfully. See Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 Duke L.J. 1071, 1159. Peer review prevents these practitioners from inappropriately treating patients. Moreover, hospitals advance their own business and competitive interests by awarding privileges selectively and thereby maintaining high standards of quality and efficiency. *Robinson v. Magovern*, 521 F. Supp. 842, 919 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459

¹⁸ The defendant peer reviewers may be able to recover the costs of their defense but only if the claim was "frivolous, unreasonable, without foundation, or in bad faith." 42 U.S.C. § 11113.

U.S. 971 (1982); *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1354 (7th Cir. 1982); Letter from Charles F. Rule, Acting Assistant Attorney General, U.S. Department of Justice, to Kirk B. Johnson, American Medical Association (Dec. 2, 1986) (discussing the position of the Antitrust Division of the U.S. Department of Justice on peer review) (attached as Appendix B). Consequently, the U.S. Department of Justice has taken the position that "the greatest potential of peer review is its ability to foster the basic goals of the antitrust laws in the health care industry—the efficient delivery of quality services in a competitive marketplace." *Id.* at pp. 5a-6a, *infra*.¹⁹ A denial of immunity, thus, would undermine the competitiveness of Oregon's health care industry.

Denying immunity will also impair Oregon's efforts to promote effective peer review. Oregon has explicitly stated its intent to protect peer reviewers from retaliatory suit by conferring upon them qualified immunity from state causes of action arising out of their peer review activities. Or. Rev. Stat. § 41.675(4). State action immunity is necessary to give effect to Oregon's provision of qualified immunity. If peer reviewers are subject to suit under federal antitrust law, disappointed physicians could easily survive motions to dismiss their legal challenges to peer review decisions, and peer reviewers would have to bear the substantial discovery and litigation burdens that are required to refute a charge of improper motive,

¹⁹ Essentially, then, peer review poses a risk to competitors, not to competition. Cf. *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962) (observing that the Sherman Act was passed for "the protection of competition, not competitors"). Indeed,

[m]uch that goes on in competitive markets is apt to seem unfair to some participants, and judges hearing plaintiffs' complaints of such unfairness often are tempted to convert antitrust law into a federal law against unfair competition or unequal bargaining instead of maintaining it as a program for promoting dynamic competition for the ultimate benefit of consumers. Havighurst, *supra*, at 1108.

whether or not their decisions were reached in good faith. *Hoover*, 466 U.S. at 580 n.34; *Pontius v. Children's Hospital*, 552 F. Supp. 1352, 1361 (W.D. Pa. 1982); Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv. L. Rev. 435, 451 (1981). Consequently, denial of state action immunity would render immunity under Oregon law largely irrelevant.

On the other hand, state action immunity is fully consistent with Oregon's qualified immunity. Oregon reasonably could conclude that the possibility of antitrust liability with its draconian treble damage and attorneys' fee provisions is excessive in deterring peer review abuses when state law remedies exist. In addition, state action immunity reflects "the pressing need to avoid the expense of antitrust litigation in an 'industry' already highly regulated and fraught with serious problems of cost and quality control." *Pontius*, 552 F. Supp. at 1361.

Whenever an immunity is granted, it is done with the recognition that a few protected individuals may abuse their immunity by acting with improper motives. Peer review is no different; abuses can occur. But, in the absence of evidence that abuse is a frequent problem, a single alleged instance of bad faith peer review should not be seized upon as a basis for adopting a rule of law that threatens to vitiate an otherwise valuable, indeed "essential,"²⁰ protection of public health. In short, a denial of immunity will frustrate Oregon's goal of effective peer review, without furthering any federal interest in enhanced competition. To the contrary, it will decrease competition.

* * *

Because of the importance of effective peer review to the public health and the need to protect peer reviewers from harassing lawsuits, states need a clear and feasible standard for granting state action immunity to peer

²⁰ H.R. Rep. No. 903, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S. Code Cong. & Admin. News 6384, 6385.

reviewers. A system of mandatory peer review, such as Oregon's, that is generally reviewed for compliance with state policy, limited by procedural safeguards and accompanied by recourse for the unfairly injured physician appropriately balances the interests of state sovereignty and federal antitrust law. It strictly satisfies the clear articulation requirement and provides a degree of active supervision that is both rigorous and practicable. Accordingly, the Court should make clear that immunity from federal antitrust suits is appropriate whenever a state employs such a system of peer review.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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January 8, 1988

APPENDICES

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APPENDIX A

The Fairfax Hospital

DELINEATION OF PRIVILEGES

Physician Name _____ Physician No. _____ Date _____

Department/Section _____ Staff Category _____

GENERAL SURGERY

Acknowledging that any detailed listing of operations and procedures will be incomplete, the following categories are requested, understanding additions may be requested and added at any time.

	<i>Routinely</i>	<i>Extenuating Circumstances Only</i>
<i>Skin, Soft Tissue, Nodes</i>		
Excision—skin lesion	_____	_____
Excision—soft tissue tumors	_____	_____
Skin graft	_____	_____
Drainage procedures	_____	_____
Node dissections	_____	_____
Pilonidal surgery	_____	_____
Management of burns	_____	_____
Others: _____	_____	_____

<i>Head and Neck</i>		
Thyroid	_____	_____
Parathyroid	_____	_____
Congenital cysts	_____	_____
Salivary gland	_____	_____
Nodes biopsies	_____	_____
Neck dissections	_____	_____
Tracheostomy	_____	_____
Neoplasms—mouth, neck, larynx	_____	_____
Diverticulectomy	_____	_____
Cervical esophageal procedures	_____	_____
Others: _____	_____	_____

<i>Chest and Breast</i>		
Biopsy lesion breast	_____	_____
Simple mastectomy	_____	_____
Radical mastectomy	_____	_____
Mammoplasty	_____	_____

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	<i>Routinely</i>	<i>Extenuating Circumstances Only</i>
Thoracostomy	_____	_____
Thoracentesis	_____	_____
Thoracotomy to manage intra- abdominal conditions	_____	_____
Bronchoscopy	_____	_____
<i>Gastrointestinal</i>		
Hiatal hernia and traumatic diaphragmatic hernia	_____	_____
Vagotomy	_____	_____
Resections and anastomotic procedures of stomach	_____	_____
Resections duodenum	_____	_____
Resections small bowel	_____	_____
Resections large bowel	_____	_____
Ostomy procedures	_____	_____
Ano-rectal surgery	_____	_____
Pyloromyotomies	_____	_____
Liver biopsy	_____	_____
Liver resection	_____	_____
Gallbladder surgery	_____	_____
C. B. D. Surgery	_____	_____
Pancreatic exploration, biopsy, resection	_____	_____
Splenectomy	_____	_____
Appendectomy	_____	_____
Drainage intra-abdominal abscess	_____	_____
Paracentesis	_____	_____
Others: _____	_____	_____
<i>GU and Retroperitoneal</i>		
Node dissections	_____	_____
Adrenalectomies	_____	_____
Sympathectomy	_____	_____
Nephrectomy	_____	_____
Ureteroplasty	_____	_____
Cystectomy	_____	_____
Circumcisions	_____	_____
Orchiopexies	_____	_____
Orchiectomy	_____	_____
Varicocelectomy	_____	_____
Hydrocolectomy	_____	_____
Vasectomy	_____	_____
Others: _____	_____	_____

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	<i>Routinely</i>	<i>Extenuating Circumstances Only</i>
<i>Vascular</i>		
Grafts	_____	_____
V. C. Ligation	_____	_____
Shunts	_____	_____
Resection Aneurysms	_____	_____
V. V. Surgery	_____	_____
Arterial peripheral vascular	_____	_____
Others: _____	_____	_____
<i>Gynecology</i>		
Salpingectomy	_____	_____
Oophorectomy	_____	_____
Hysterectomy	_____	_____
D & C	_____	_____
Fistulectomy	_____	_____
Perineal repairs	_____	_____
Others: _____	_____	_____
<i>Extremities and Abdominal Wall</i>		
Ganglionectomy	_____	_____
Tenorrhaphies	_____	_____
Drainage abscess	_____	_____
Amputations	_____	_____
All hernia repairs	_____	_____
Others: _____	_____	_____
<i>Miscellaneous</i>		
Endoscopy and Biopsy	_____	_____
Laparoscopy	_____	_____
Regional Blocks	_____	_____
—biopsy thyroid and parathyroid	_____	—biopsy diaphragm, abdominal cavity
—biopsy stomach, intestine	_____	—biopsy biliary tract, spleen, pancreas
—biopsy urinary tract	_____	—biopsy male genital organs
—biopsy breast	_____	—biopsy internal female genital organs
—biopsy circulatory/lymphatic systems	_____	—biopsy skin and subcutaneous

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—biopsy adrenal, kidney,
perirenal
—biopsy other musculoskeletal
—Swan Ganz

—biopsy bone, including marrow
—other

(signature)

Approved by Credentials Committee—9/25/80
Recommended by Executive Committee—10/14/80
Approved by the Board of Trustees—10/22/80

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APPENDIX B

[SEAL]

U.S. Department of Justice
Antitrust Division
Washington, D.C. 20530

Office of the Assistant Attorney General

December 2, 1986

Kirk B. Johnson, Esq.
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Dear Mr. Johnson:

This letter responds to your letter of November 26, 1986, requesting that the Antitrust Division of the Department of Justice address a matter that is of considerable importance to the medical community. Your letter states that many physicians are concerned about whether members of the medical staff of a hospital may incur liability under the antitrust laws when they participate in the credentialing or "peer review" process at a hospital. You requested the Division address the question, "whether good faith peer review activities designed and reasonably conducted to prevent incompetent physicians from obtaining or maintaining staff privileges violate the antitrust laws."

It would be most unfortunate if physicians refrained from participating in hospital peer review activity because of an unwarranted fear that such participation was likely to pose serious concerns under the federal antitrust laws. Put simply, there is no reason to expect a clash between the antitrust laws and peer review conducted to eliminate incompetence in the delivery of health care services. Quite to the contrary, the greatest potential of peer review is its ability to foster the basic goals of the anti-

trust laws in the health care industry—the efficient delivery of quality services in a competitive marketplace.

There are fundamental reasons for the harmony between antitrust policy and legitimate peer review. Correctly interpreted, the antitrust laws reflect the fact that the protection of competition in a health care market does not dictate that a hospital accord privileges to every practitioner who desires to use its facilities—the antitrust laws protect competition, *not competitors*. A hospital, therefore, is justified in according privileges in a selective manner so as to maintain high standards of quality and efficiency, in furtherance of its own business and competitive objectives. In addition, a hospital may legitimately decide to deny privileges to an incompetent practitioner, based on good faith peer review conducted by the medical staff. Although the denial of privileges might make it difficult or even impossible for the practitioner to engage in his profession, such a denial does not impair competition. Rather, because the denial will enhance the quality and efficiency of health care and thereby strengthen the hospital's competitive position, peer review serves the underlying goals of the antitrust laws.

The benefits of peer review in eliminating incompetence in the provision of health care are recognized not only in traditional antitrust analysis, but also in the recently enacted "Health Care Quality Improvement Act of 1986," which the President signed on November 14, 1986. That legislation immunizes health care entities and physicians from damage liability for participating or assisting in peer review determinations that deny or restrict a physician's hospital privileges on competency grounds, provided that such determinations are reached pursuant to fair procedures and meet other specified standards. In essence, the new law provides an antitrust immunity from damages for legitimate peer review that attempts in good faith to weed out incompetent physicians.

Compliance with the provisions of the Health Care Quality Improvement Act of 1986 should provide immunity from damages for a peer review determination denying or restricting the hospital privileges of an incompetent physician. Of course, even if a peer review determination does not qualify for such immunity, that does not necessarily mean that the peer review violates the antitrust laws. Indeed, only in the exceptional circumstance where the peer review process is not used to review individual competence but rather is a sham used to exclude a competent practitioner or group of practitioners from the market and thus to restrain competition, would an antitrust violation ever exist.

In closing, it bears repeating that the antitrust laws do not stand in the way of physicians' participation in hospital peer review conducted to identify and restrain incompetence in the provision of health care. To the contrary, because such peer review enhances both the quality and efficiency of the services delivered in our nation's hospitals to the benefit of consumers, it furthers the antitrust goal of fostering competition in the health care marketplace.

Sincerely,

/s/ Charles F. Rule
CHARLES F. RULE
Acting Assistant
Attorney General